State of Connecticut
GENERAL ASSEMBLY

Medical Assistance Program Oversight Council
Legislative Office Building, Room 3000, Hartford, CT 06106
* (860) 240-0321 * Info Line (860) 240-8329 * FAX (860) 240-5306 *
www.cga.ct.gov/med/

Medical Assistance Program Oversight Council

Biannual Reports: CY 2015 QTS 1 & 2, 3 & 4

Date: January 15, 2016

To: The Connecticut General Assembly

From: Richard Eighme, Administrative Assistant

Subject: MAPOC 2015 Biannual Reports

This report of the Medical Assistance Program Oversight Council is hereby submitted to the Connecticut General Assembly, pursuant of 17b-28 subsec. (i) of the Connecticut General Statutes, subject to the time period of January to December 2015.

Sincerely,

Senator Terry Gerratana
Co-Chair of MAPOC
Chair, Public Health Committee

Representative Cathy Abercrombie
Co-Chair of MAPOC
Chair, Human Services Committee

Richard Eighme
Administrative Assistant

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Biannual Reports

CY 2015 Quarters: 1 & 2, 3 & 4

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Acronyms and Abbreviations

AHCT	Access Health Connecticut
AMH	Advanced Medical Home (SIM)
ASO	Administrative Service Organization
AWP	Average Wholesale Price
BHP	Behavioral Health Partnership
BHPOC	Behavioral Health Partnership Oversight Council
CAC	Consumer Access Committee
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCC	Complex Care Committee
CCIP	Community and Clinical Integration Program (SIM)
CCT	Community Care Team
CGA	Connecticut General Assembly
CGS	Connecticut General Statutes
CHA	Connecticut Hospital Association
CHC	Community Health Center
CHC-ACT	Community Health Center Association of Connecticut
CHIP	Children's Health Insurance Program
CHN-CT	Community Health Network of Connecticut
CHW	Community Health Worker
CMAP	Connecticut Medical Assistance Program
CMC	Care Management Committee
CMCS	Center for Medicaid and CHIP Services (CMS)
CMMI	Center for Medicare & Medicaid Innovation (CMS)
CMS	Centers for Medicare & Medicaid Services
DCF	Department of Children and Families
DHP	Dental Health Partnership (Also: CTDHP)
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DOC	Department of Correction
DSS	Department of Social Services
EAC	Equity and Access Council (SIM)
EBT	Electronic Benefit Transfers
ED	Emergency Department
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
ICM	Intensive Care Management
ICM	Integrated Care Model
LOB	Legislative Office Building
LTSS	Long-Term Services and Supports
MAPOC	Medical Assistance Program Oversight Council
MFP	Money Follows the Person
MQISSP	Medicaid Quality Improvement and Shared Savings Program
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
OBP4P	Obstetric Pay for Performance
OEC	Office of Early Childhood
OFA	Office of Fiscal Analysis
OPM	Office of Policy Management
PCMH	Person-Centered Medical Home
PCP	Primary Care Physician
PMO	Project Management Office (SIM)
PNA	Personal Needs Allowance
PTN	Practice Transformation Network
PTTF	Practice and Transformation Taskforce (SIM)
QI	Quality Improvement
RFP	Request for Proposal
SIM	State Innovation Model
SNAP	Supplemental Nutrition Assistance Program
TFA	Temporary Family Assistance
VO	Value Options
WIC	Women, Infants and Children

Overview of the Council

The Medical Assistance Program Oversight Council (MAPOC) biannual reports are submitted to the General Assembly as required under CGS 17b-28 subsec. (i). The Medical Assistance Program Oversight Council, previously called the Medicaid Managed Care Council, is a collaborative body established by the General Assembly in 1994 to initially advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program (HUSKY A).

Legislation in 2011 revised 17b-28 to include Council oversight of the Medicaid HUSKY Health Program that encompasses all Medicaid enrollees' health care. The statute charges the Council with monitoring and advising DSS on matters including, but not limited to, program planning and implementation of the new delivery system under the Administrative Service Organization (ASO), transitional issues from managed care to this model, eligibility standards, benefits, health care access and quality measures.

The Council consists of legislators, consumers, advocates, health care providers, administrative service organization representatives and state agency/commission personnel as defined in statute. An updated membership list can be found at: https://www.cga.ct.gov/med/about-members.asp.

The Council has several sub-committees to give attention to the wide facets of Medical Assistance. They currently include the Consumer Access, Care Management, Women's Health, and Complex Care Committees. Sub-committees are comprised of members of MAPOC and ex-officio persons, whose knowledge and expertise provide advisement to the particular subject matter of Medical Assistance. Depending on the needs of the Council they meet monthly, bimonthly and Ad-Hoc.

In 2014 the standing subcommittee on Cost Savings was established, under CGS 17b-28 subsec. (h), to make annual recommendations to the Council on evidence-based best practices concerning Medicaid cost savings. Membership of this standing subcommittee is defined in Statute.

Records of the Council and sub-committee meetings are kept on file in the Public Health Joint Standing Committee of the Connecticut General Assembly and are all available on the MAPOC website at www.cga.ct.gov/med/. Information about the Council, updates, additional documents and useful links can also be found at this site.

Section 17b-28 CT General Statutes

Sec. 17b-28. Council on Medical Assistance Program Oversight. Duties. Appointments. Funding. Standing subcommittee. Reports. (a) There is established a Council on Medical Assistance Program Oversight which shall advise the Commissioner of Social Services on the planning and implementation of the health care delivery system for the following health care programs: The HUSKY Plan, Parts A and B and the Medicaid program, including, but not limited to, the portions of the program serving low income adults, the aged, blind and disabled individuals, individuals who are dually eligible for Medicaid and Medicare and individuals with preexisting medical conditions. The council shall monitor planning and implementation of matters related to Medicaid care management initiatives including, but not limited to, (1) eligibility standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome measures, and (6) the issuance of any request for proposal by the Department of Social Services for utilization of an administrative services organization in connection with such initiatives.

(b) On or before June 30, 2011, the council shall be composed of the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies, or their designees; two members of the General Assembly, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; the director of the Commission on Aging, or a designee; the director of the Commission on Children, or a designee; a representative of each organization that has been selected by the state to provide managed care and a representative of a primary care case management provider, to be appointed by the president pro tempore of the Senate; two representatives of the insurance industry, to be appointed by the speaker of the House of Representatives; two advocates for persons receiving Medicaid, one to be appointed by the majority leader of the Senate and one to be appointed by the minority leader of the Senate; one advocate for persons with substance use disorders, to be appointed by the majority leader of the House of Representatives; one advocate for persons with psychiatric disabilities, to be appointed by the minority leader of the House of Representatives; two advocates for the Department of Children and Families foster families, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; two members of the public who are currently recipients of Medicaid, one to be appointed by the majority leader of the House of Representatives and one to be appointed by the minority leader of the House of Representatives; two representatives of the Department of Social Services, to be appointed by the Commissioner of Social Services; two representatives of the Department of Public Health, to be appointed by the Commissioner of Public Health; two representatives of the Department of Mental Health and Addiction Services, to be appointed by the Commissioner of Mental Health and Addiction Services; two representatives of the Department of Children and Families, to be appointed by the Commissioner of Children and Families; two representatives of the Office of Policy and Management, to be appointed by the Secretary of the Office of Policy and Management; and one representative of the office of the State Comptroller, to be appointed by the State Comptroller.

(c) On and after July 1, 2011, the council shall be composed of the following members:

(1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services, public health and appropriations and the budgets of state agencies, or their designees;
(2) Five appointed by the speaker of the House of Representatives, one of whom shall be a member of the General Assembly, one of whom shall be a community provider of adult Medicaid health services, one of whom shall be a recipient of Medicaid benefits for the aged, blind and disabled or an advocate for such a recipient, one of whom shall be a representative of the state's federally qualified health clinics and one of whom shall be a member of the Connecticut Hospital Association;
(3) Five appointed by the president pro tempore of the Senate, one of whom shall be a member of the General Assembly, one of whom shall be a representative of the home health care industry, one of whom shall be a primary care medical home provider, one of whom shall be an advocate for Department of Children and Families foster families and one of whom shall be a representative of the business community with experience in cost efficiency management;
(4) Three appointed by the majority leader of the House of Representatives, one of whom shall be an advocate for persons with substance abuse disabilities, one of whom shall be a Medicaid dental provider and one of whom shall be a representative of the for-profit nursing home industry;
(5) Three appointed by the majority leader of the Senate, one of whom shall be a representative of school-based health centers, one of whom shall be a recipient of benefits under the HUSKY program and one of whom shall be a physician who serves Medicaid clients;
(6) Three appointed by the minority leader of the House of Representatives, one of whom shall be an advocate for persons with disabilities, one of whom shall be a dually eligible Medicaid-Medicare beneficiary or an advocate for such a beneficiary and one of whom shall be a representative of the not-for-profit nursing home industry;
(7) Three appointed by the minority leader of the Senate, one of whom shall be a low-income adult recipient of Medicaid benefits or an advocate for such a recipient, one of whom shall be a representative of hospitals and one of whom shall be a representative of the business community with experience in cost efficiency management;
(8) The executive director of the Commission on Aging, or the executive director's designee;
(9) The executive director of the Commission on Children, or the executive director's designee;
(10) A representative of the Long-Term Care Advisory Council;
(11) The Commissioners of Social Services, Children and Families, Public Health, Developmental Services and Mental Health and Addiction Services, and the Commissioner on Aging, or their designees, who shall be ex-officio nonvoting members;
(12) The Comptroller, or the Comptroller's designee, who shall be an ex-officio nonvoting member;

(13) The Secretary of the Office of Policy and Management, or the secretary's designee, who shall be an ex-officio nonvoting member; and
(14) One representative of an administrative services organization which contracts with the Department of Social Services in the administration of the Medicaid program, who shall be a nonvoting member.

(d) The council shall choose a chairperson from among its members. The Joint Committee on Legislative Management shall provide administrative support to such chairperson.

(e) The council shall monitor and make recommendations concerning: (1) An enrollment process that ensures access for each Department of Social Services administered health care program and effective outreach and client education for such programs; (2) available services comparable to those already in the Medicaid state plan, including those guaranteed under the federal Early and Periodic Screening, Diagnostic and Treatment Services Program under 42 USC 1396d; (3) the sufficiency of accessible adult and child primary care providers, specialty providers and hospitals in Medicaid provider networks; (4) the sufficiency of provider rates to maintain the Medicaid network of providers and service access; (5) funding and agency personnel resources to guarantee timely access to services and effective management of the Medicaid program; (6) participation in care management programs including, but not limited to, medical home and health home models by existing community Medicaid providers; (7) the linguistic and cultural competency of providers and other program facilitators and data on the provision of Medicaid linguistic translation services; (8) program quality, including outcome measures and continuous quality improvement initiatives that may include provider quality performance incentives and performance targets for administrative services organizations; (9) timely, accessible and effective client grievance procedures; (10) coordination of the Medicaid care management programs with state and federal health care reforms; (11) eligibility levels for inclusion in the programs; (12) enrollee cost-sharing provisions; (13) a benefit package for each of the health care programs set forth in subsection (a) of this section; (14) coordination of coverage continuity among Medicaid programs and integration of care, including, but not limited to, behavioral health, dental and pharmacy care provided through programs administered by the Department of Social Services; and (15) the need for program quality studies within the areas identified in this section and the department's application for available grant funds for such studies. The chairperson of the council shall ensure that sufficient members of the council participate in the review of any contract entered into by the Department of Social Services and an administrative services organization.

(f) The Commissioner of Social Services may, in consultation with an educational institution, apply for any available funding, including federal funding, to support Medicaid care management programs.

(g) The Commissioner of Social Services shall provide monthly reports to the council on the matters described in subsection (e) of this section, including, but not limited to, policy changes and proposed regulations that affect Medicaid health services. The commissioner shall also provide the council with quarterly financial reports for each covered Medicaid population which reports shall include a breakdown of sums expended for each covered population.

(h) There is established, within the Council on Medical Assistance Program Oversight, a standing subcommittee to study and make annual recommendations to the council on evidence-based best practices concerning Medicaid cost savings. The subcommittee shall file its first report to the council not later than January 1, 2015. The subcommittee shall consist of the following members, whose work on the council shall consist solely of work on the subcommittee:
(1) One appointed by the speaker of the House of Representatives, who shall be a member of the Connecticut Hospital Association;
(2) One appointed by the president pro tempore of the Senate, who shall be a representative of the business community with experience in cost efficiency management;
(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the for-profit nursing home industry;
(4) One appointed by the majority leader of the Senate, who shall be a physician who serves Medicaid clients;
(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of the not-for-profit nursing home industry; and
(6) One appointed by the minority leader of the Senate, who shall be a representative of the business community with experience in cost efficiency management.
(i) The subcommittee established pursuant to subsection (h) of this section shall choose chairpersons from among its members.
(j) The council shall biannually report on its activities and progress to the General Assembly.

Council Biannual Report:

Quarters 1 & 2

Council Biannual Report: Quarters 1 & 2

In January, the Council received a ConneCT Dashboard update and presentation on enrollment through Access Health CT. CT Voices for Children gave a presentation on the Husky A Dental Care for young children, pregnant women and mothers.
Attachments:

- DSS- ConneCT Dashboard Update
- Access Health CT Presentation
- CT Voices for Children- Husky A Dental Care

In February, The Department of Social Services provided the Council with an update on Husky enrollment and an overview of the Husky renewal process. CT Voices for Children gave a presentation on coverage continuation and gaps in the Husky program.
Attachments:

- Husky Enrollment Update
- Husky Renewal Process Presentation
- CT Voices for Children- Coverage Continuation and Gaps in Husky Program

In April, the Council reviewed a letter from the Complex Care Committee on the funding for the dually eligible pilot initiative. DSS provided a presentation on enrollment and eligibility, which included an update on ConneCT. The presentation reflected the past, current and future state of the Department's enrollment process.
Attachments:

- DSS Enrollment and Eligibility Presentation
- Complex Care Committee- Dually Eligible Position Letter

In May, the Council received an overview on the State's WIC Program from DPH. An overview was given of Access Health CT's enrollment process and call center. ValueOptions gave a presentation on the Behavioral Health Partnership call center and process of member referrals. Logisticare's presentation was postponed until a future meeting.
Attachments:

- WIC Program Presentation
- ValueOptions: BHP Call Center and Process of Member Referals
- Access Health CT Enrollment Process Presentation
- Logisitcare Presentation

In June, DSS gave an update on Connecticut's Medicaid Integration Initiatives. These include DMHAS Behavioral Health Homes, the Duals Demonstration Health Neighborhood Model and the Medicaid Quality Improvement and Shared Savings Program (MQISSP). A document was distributed from Logisitcare to MAPOC, answering questions posed by an advocate.
Attachments:

- MQISSP Brief Primer
- Medicaid Integration Projects Detailed Comparison Chart
- Medicaid Integration Projects Infographic
- Medicaid Integration Projects Short Form Comparison Chart
- Logisticare Response to Questions

Sub-Committee Biannual Reports: Quarters 1 & 2

Care Management Committee

In January, the committee received an update on Person Centered Medical Homes (PCMH). Discussion was had on the draft protocol for work between the PCMH Committee and the SIM Councils. SIM quality measures were reviewed.
Attachment:

- PCMH Update

In February, the committee discussed protocol for work in support of the State Innovation Model (SIM) Medicaid Quality Improvement and Shared Savings Program (MQISSP). A draft of the MQISSP timeline and pathway to SIM implementation were reviewed. A document containing PCMH quality performance measures was distributed.
Attachments:

- Protocol for Work in Support of SIM
- Draft Timeline
- Draft Pathway
- PCMH Quality Measure Set

In April, the Committee discussed the implementation of The Medicaid Quality Improvement and Shared Savings Program (MQISSP). MQISSP is being designed under the State Innovation Model (SIM) to improve the health outcomes and fulfillment of Medicaid recipients being served by providers. DSS is currently working with Mercer on specific areas of attention that must gradually be applied into the initiative. The stakeholdering timeline and clinical quality measure proposal were reviewed.
Attachments:

- Brief Primer on MQISSP
- Draft MQISSP Care Management Stakeholdering Timeline
- MQISSP Clinical Quality Measure Proposal

In May, DSS had the committee review two documents including a brief primer on MQISSP and the stakeholdering timeline. Members reviewed the provisional measures of the SIM quality measure set and Exhibit E of the CHNCT medical contract for comparison to the proposed MQISSP quality measures and potential new PCMH measure set.
Attachments:

- Revised Brief Primer on MQISSP
- Revised MQISSP Care Management Stakeholdering Timeline
- SIM Provisional Quality Measure Set - Appendix
- Provisional SIM Quality Council Measure Set
- SIM Quality Measure Set interaction with MAPOC and HISC
- CHNCT Medical Exhibit E Reporting Matrix
- MQISSP Clinical Quality Measure Set Proposal
- Draft PCMH Pediatric Quality Measures- Current vs. Potential New

In June,. Mercer distributed a draft document of the attributed members of MQISSP. Discussion took place on which populations should and should not be included in the initiative.
Attachment:

MQISSP Attributed Members

In June, DSS and Mercer held its first MQISSP webinar for the Care Management Committee on quality measure set development.

Complex Care Committee

In March, the Duals Initiative was discussed amongst members. An update was given on the status of CMS discussions and the impact of the Governor's Budget Recommendations.

In April, the committee reviewed a drafted letter that would be sent out as an attachment to the full Council. CHN-CT gave a presentation on care analyzer/data risk stratification. The council engaged in conversation about future topics that could be discussed dealing with complex care.

Attachments:

Draft letter on Duals
CHN Presentation

In May, the committee held a meeting of the chairs, select members and DSS to discuss future topics for the subcommittee to engage in.

In June, the committee received an update on the Duals Initiative which lost funding under the FY16 & FY17 State Budget. ValueOptions presented on frequent behavioral health ED visits of high risk populations. CHN-CT provided data on the work being done to reduce inappropriate ED utilization.

Attachments:

ValueOptions Presentation
CHNCT ED Utilization Report

Consumer Access Committee

In February, the subcommittee nominated two new Co-Chairs (Brenetta Henry and Benita Toussaint) to the committee in addition to Christine Bianchi and Janine Sullivan-Wiley. An update on Non-Emergency Medical Transportation (NEMT) was received. Discussion was had on the draft comments for new regulations.

In March, CHN-CT presented the ASO's Husky quarterly grievance reports for October to December 2014. ValueOptions presented the Quarter 4 grievance report for 2014. A draft NEMT Consumer Checklist was distributed that would be discussed at a future meeting.

In April, the CT Dental Health Partnership provided a report on grievances for the 4th quarter of 2014. LogistiCare gave a presentation on updates of The Non-Emergency Medical Transportation Program (NEMT). A Brochure was distributed that is given to CT members.

Attachments:

CT Dental Health Partnership Grievance Report
Logisitcare Presentation

CT Member Brochure - NEMT

In May, DSS gave a presentation on Medical Spend Down. Members discussed priority planning for the remainder of 2015. The draft NEMT Consumer Checklist was brought to the committee's attention.

Attachments:

Medical Spend Down Presentation.

Women's Health Committee

In May, Guests were present to discuss OB Services for Pregnant Women and the effects of Churning. Conversation was had on the Healthy Start Program. DSS expressed that the program was being handed over to the Office of Early Childhood.

Council Biannual Report:

Quarters 3 & 4

In July, DSS gave a presentation on benefit center enrollment and eligibility. The Council discussed the Medicaid cuts that would lead to some Husky A parents losing eligibility. DSS shared a video which included testimonials, outlining Connecticut's Medical Assistance Program and celebrating the 50th Anniversary of Medicaid. A letter was distributed that was sent to Commissioner Bremby, from Connecticut Legal Services on the implementation of the change in income eligibility for parents under the HUSKY A program.
Attachments:

- Husky Benefit Center Enrollment and Eligibility
- CT Legal Services Letter

In September, letters were discussed that were sent out to DSS and AHCT requesting a presentation at the November meeting on the required report on the transition of Husky A parents who lost their coverage to the Insurance Exchange. DSS provided an update on the State's Non-Emergency Medical Transportation (NEMT) program. DSS gave an update on the Application Timeliness of the HUSKY Program. CT Voices for Children went through the documents available for distribution to the Council.
Attachments:

- Benefit Center Process Flow Chart
- Husky Application Timeliness Update
- Non-Emergency Medical Transportation Update

In October, DSS gave a report on eligibility process improvement which reviewed the business process, ongoing efforts and the October Dashboard. DSS and Mercer presented an overview of the Medicaid Quality Improvement and Shared Savings Program (MQISSP). The presentation included an overview of MQISSP, an analysis of the context setting, and reviewing the model design process and key design features. The Husky Performance Monitoring done by CT Voices for Children was presented.
Attachments:

- MQISSP Overview Presentation
- MQISSP Key Model Design Documents
- Husky Eligibility Process Improvement Update
- Husky Performance Monitoring- CT Voices for Children

In November, DSS provided an Update on Husky enrollment and information on the 1095 B Tax Form. DSS and Access Health CT shared information on the transition of Husky A adults as required under Public Act No. 15-5. A document was provided by DSS outlining Connecticut's Participation in the National Governor's Association's, High Need High Cost Policy Academy.
Attachments:

- Husky Enrollment Update
- 1095 B Tax Form Information
- Transition of Husky A Adults
- Outline of NGA's High Need High Cost Policy Academy

In December, DSS provided an overview of Connecticut's Participation in the NGA High Need, High Cost Policy Academy. The Council Reviewed a Draft of the 2015 MAPOC Report to the Legislature.

Attachments:

NGA Policy Academy Presentation
Draft 2015 MAPOC Report

Care Management Committee

In July, an update on Person Centered Medical Homes (PCMH) was distributed and the June webinar was discussed. The Committee reviewed the SIM Equity and Access Council's draft recommendations on safeguarding against under-service and patient selection in context of shared savings payment arrangements. This led to discussion on the draft document provided by Mercer on the benefits in the shared savings calculation for MQISSP.

Attachments:

- PCMH Update
- SIM EAC Recommendations
- Benefits in Shared Savings Calculation
- Benefits in Shared Savings Calculation Checklist

In July, DSS and Mercer held its second webinar for the Care Management Committee on quality measure set development and evaluation of SIM quality measures.

In August, Mercer provided a full update on MQISSP including its project management, operations, clinical and actuarial aspects. A briefing was given along with many different handouts that were reviewed and discussed by the committee. A new MQISSP timeline was distributed which factored in the new extensions.

Attachments:

- MQISSP Briefing Presentation
- MQISSP Concept Paper for CMS
- MQISSP Elements
- MQISSP Participating Entity Qualifications
- MQISSP Proposed Measure List
- MQISSP Shared Savings Payment Principles
- Draft MQISSP Timeline with Extensions

In August, DSS and Mercer held its third Webinar for the Care Management Committee on quality measure set development and evaluation of SIM quality measures.

In September, DSS and Mercer held a conference call on MQISSP attribution for the Committee.

In September, the SIM practice and transformation taskforce (PTTF) gave a presentation on the Community and Clinical Integration Program (CCIP). DSS provided an update on the PCHM program.. A document on Quality Measures and Domains was distributed.

Attachments:

- CCIP Presentation
- PCMH Update
- Measures and Domains - CY 2013

In September, DSS and Mercer held a webinar for the Care Management Committee on Enhanced Care Coordination Activities.

In September, DSS and Mercer held a work group to review several aspects of MQISSP including: under-service utilization monitoring, quality measure set rankings and model design.

In September, the Committee held a second meeting to continue its work on MQISSP. The work group's work on under-service utilization monitoring, quality measure set rankings and model design was discussed. The Committee spent most of its meeting reviewing the Model design of MQISSP.
Attachments:

- MQISSP Measure Set Rankings
- MQISSP Under-Service Utilization Strategy
- MQISSP Model Design

In October, DSS announced its milestone of reaching over 100 participants in its PCMH program. The Department confirmed that the requested extension in the implementation of MQISSP was approved. With this, a new timeline for MQISSP was reviewed along with a Stakeholder Grid. The process for reviewing comments and outstanding issues was discussed.
Attachments:

- PCMH 100th Milestone Update
- Proposed MQISSP Model Design Timeline
- Draft MQISSP Timeline

In November, SIM held a webinar on the Community and Clinical Integration Program for the Care Management Committee.
Attachment:

- CCIP Webinar Presentation

In November, DSS and Mercer held a work group to review several aspects of MQISSP including: the concept paper, provider qualifications and under-service utilization monitoring.

In November, the committee met an hour early to allow time for an open discussion on MQISSP. DSS and CHNCT presented an update on the PCMH program. DSS shared a document and discussed Medicaid and SIM Care Coordination and Practice Transformation Initiatives. Mercer discussed the workgroup and what was needed moving into December on MQISSP.
Attachments:

- PCMH Update
- Medicaid and SIM Care Coordination and Practice Transformation Initiatives
- Updated Draft MQISSP Concept Paper for CMS

In December, DSS and Mercer held a MQISSP webinar on Provider Qualifications.
Attachments:

- MQISSP Participating Entity Foundational and Working Assumptions
- MQISSP Participating Entity Oversight Requirements

In December, DSS and Mercer held a work group to review several aspects of MQISSP including: entity oversight requirements, participating entity working assumptions and a proposed communication plan development phase.

In December, Mercer presented the participating entity oversight requirements of MQISSP. The committee reviewed and discussed participating entity working assumptions and a proposed communication plan development phase. DSS gave a timeframe for comments to be submitted on the MQISSP Concept paper before it is submitted to CMS.

Attachments:

Participating Entity Oversight Requirements
Participating Entity Working Assumptions
Proposed Communication Plan Development Phase
Updated Draft Concept Paper

Complex Care Committee

In July, the Department of Social Services gave a brief update on the Duals Initiative. DSS provided a presentation on long term services and supports rebalancing initiatives. A document outlining CT's Medicaid long term services and supports rebalancing initiatives was distributed.

Attachments:

Rebalancing Initatives Presentation
Long Term Services and Supports Rebalancing Initiatives

In September, CHN-CT gave a report on high ED utilizers in the Husky program. Requested data was provided on the service. Future meeting topics were discussed.

Attachments:

Husky High ED Utilization Presentation

In October, the committee reviewed innovative hospital and community collaborations through Community Care Teams. Middlesex Hospital provided a presentation on their Community Care Team. The CT Hospital Association gave an overview on the development of teams around the state. ValueOptions and CHN gave a presentation on ASO's work with hospitals and community care teams. DSS gave a brief overview of the work being done and the CMS Grant for community care teams.

Middlesex Hospital Community Care Teams
ValueOptions and CHN-CT Community Care Team Presentation

In December, DSS presented on its and other agencies involvement in a National Governor's Association policy academy on high need, high cost individuals. An application for the academy and an inventory of current and prospective Medicaid and State-Funded intervention efforts was distributed.

Attachments:

NGA Policy Academy Application
NGA Policy Academy Inventory

Consumer Access Committee

In September, the subcommittee received a presentation from DSS, outlining the basics of the state's NEMT program.. The committee received a draft NEMT grievance report.

The chairs discussed committee membership and expanding to include more geographic state representation.
Attachments:

NEMT Basics Presentation
Draft NEMT Grievance Report

In October, CHN-CT provided a presentation on Husky Grievances. Two documents were distributed that outlined complaints by reason code and complaints meeting turnaround time. Draft NEMT reports were distributed and reviewed. The Chairs provided updates on the expansion of committee membership.
Attachments:

CHN-CT Husky Grievance Presentation
Husky Complaints by Reason Code
Q3 2015 Complaints Meeting Turnaround Time
Draft NEMT Complaint Report - p.1
Draft NEMT Complaint Report - p.2
Draft NEMT Trip Report

In December, DSS and Logisticare provided an update on the NEMT/Logisticare Quarterly Grievance Report and a review of the 2014 Mercer findings and responsive updates The 2016 Committee goals and objectives were discussed.
Attachments:

Mercer Document Review and Logisitcare Updates
Draft NEMT ASO Grievance Report

Women's Health Committee

In July, a presentation was provided on Cytomegalovirus. The Governor had recently signed House Bill 5525: An Act Concerning Cytomegalovirus, which requires a screening test for cytomegalovirus for newborns who fail a newborn hearing screening. DSS gave an OBP4P update which would be implemented for the second time. The Medicaid Quality Improvement and Shared Savings Program (MQISSP) was reviewed.
Attachment:

Cytomegalovirus Presentation

In September, DSS provided the committee with an update on Obstetric Pay for Performance (OBP4P). The Office of Early Childhood (OEC) gave an update on the Healthy Start Program which was initially administered under DSS.
Attachment:

OBP4P Presentation

In November, a presentation was received on the Connecticut K.I.D. Program and substance exposed infant's in-depth technical assistance. The Department of Public Health displayed the video, Crisis in the Crib: Saving Our Nation's Babies. The March of Dimes shared the Connecticut Premature Birth Report Card.
Attachments:

CT K.I.D.
CT Premature Birth Report Card

In December, The Office on Women's Health at the U.S. Department of Health and Human Services provided an overview of women's health priority areas. A presentation was given on SIM and its initiatives. DMHAS provided a document outlining women and children's residential treatment programs.

Attachment:

SIM overview for Women's Health

Cost Savings Subcommittee

The Cost Savings Committee did not hold a meeting in 2015. The following document was drafted and distributed to members in December, 2015. It represents financial implications and initiatives in the State's Medicaid Program that may have represented savings during the year. The document will be used as a starting point for meetings and discussions going into 2016 along with data on Medicaid financial trends that will be shared with the full MAPOC Council during January's meeting.

Overview of 2015 Medicaid Cost Savings:

Submitted to the Cost Savings Subcommittee on December 24, 2015

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I. The State Budget

In 2015, the Governor and Legislature undertook several Medicaid cuts and cost saving measures as part of the State's Biennial Budget. The following highlights these expenditure adjustments.[1]

	Actual	Governor Estimated	Governor Recommended		Legislative	
	FY 14	**FY 15**	**FY 16**	**FY 17**	**FY16**	**FY 17**
Medicaid	2,451,456,880	2,399,268,579	2,446,290,000	2,505,490,000	2,468,415,500	2,542,788,000

A. General Reductions

The Legislature reduced funding to the Medicaid account by $17.5 million in both FY 16 and FY 17.[2]

The Legislature reduced funding to the Medicaid account by $67.6 million in FY 16 and $54.2 million in FY 17 to correctly reflect the state's share of Medicaid expenditures following the account being established as a net appropriation in FY 14. [3]

* (*Note: The Governor's Budget originally reduced Medicaid provider rates. The Legislature maintained funding to the provider rates, for FY 16 and FY 17, of $43 million and $47 million respectively.*)

B. Reductions based on anticipated Federal Reimbursement

To reflect the increase in Federal share from implementing the Community First Choice Option, funding was reduced by $750,000 in FY 16 and FY 17.[4]

Additional Federal Revenue from the greater match on the Medicaid supplemental hospital payments will be used to offset other Medicaid expenses allowing a reduction of $13,320,000 in FY 16 and FY 17.[5]

Federal reimbursement for certain substance abuse programs allows for a reduction in funding of $2,230,000 in FY 16 and FY 17. This requires a state plan change and therefore approval from CMS.[6]

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[1] Numbers and Analysis provided by the Office of Fiscal Analysis. CONNECTICUT STATE BUDGET: FY 16 & FY 17 Budget, *October 7, 2015*.
https://www.cga.ct.gov/ofa/Documents/year/BB/2016BB-20151007_FY%2016%20and%20FY%2017%20Connecticut%20Budget.pdf
[2] Ibid., p.341
[3] Ibid., p.333
[4] Ibid., p.335
[5] Ibid., p.335
[6] Ibid., p.348

Funding is reduced by $27,140,000 in FY 16 and $31.9 million in FY 17 to reflect the net appropriation of the Husky B program, not including the gross appropriation of both state and federal share. After October 1, 2015 federal reimbursement rate for the program will increase form 65% to 88% through September 30, 2019.[7] (See also: providing of funding of $5,645,000 in FY 16 and $8,214,000 in FY 17 for anticipated requirements of Husky B.[8])

C. Reductions based on DSS initiatives to lower Medicaid costs

In response to projected FY 15 deficiency, The Department of Social Services enacted several initiatives to lower Medicaid expenses. These led to the following reductions in funding based on Annualization of Savings:

- $4,740,000 in FY 16 and FY 17 to reflect savings from revising agreements for certain high cost drugs.[9]

- $4,390,000 in FY 16 and $4.6 million in FY 17 to reflect savings from reimbursement changes to certain screening codes.[10]

- $3,730,000 in FY 16 and $3,870,000 in FY 17 to reflect savings from changes in physician radiology rates.[11]

- $2,170,000 in FY 16 and FY 17 to reflect savings from changing physician reimbursement based on facility type code.[12]

- $2,415,000 in FY 16 and $2,685,000 in FY 17 to reflect savings from other initiatives.[13]

- $2,085,000 in FY 16 and $2,175,000 in FY 17 to reflect savings from changing obstetrical rates. This is different than the Governor's proposal because it reflects a restoration in funding from FY 15 and funding support to obstetricians' involved in high risk pregnancy imaging.[14]

- $2,052,000 in both FY 16 and FY 17 to reflect savings from moving the minimum qualifying score on the Salzmann index from 24 to 26. This is different than the Governor's proposal which saw more savings by moving the minimum qualifying score from 24 to 29.[15]

[7] Ibid., p.346
[8] Ibid., p.337
[9] Ibid., p.334
[10] Ibid., p.334
[11] Ibid., p.335
[12] Ibid., p.340
[13] Ibid., p.335
[14] Ibid., p.340
[15] Ibid., p.342

D. Other Reductions

Medicaid funding is reduced by $2.4 million in FY 16 and $43.5 million in FY 17 reflecting the elimination of Husky "A" coverage for non-pregnant adults whose incomes are greater than 150% of the federal poverty level. This is different than the Governor's original proposal which eliminated coverage for those whose incomes were greater than 138% of the federal poverty level (See sections: 370-374 of PA 15-5 JSS; a budget implementer).[16]

Funding is reduced by $900,000 in FY16 and $3.6 million in FY 17 as a result of the implementation of an Automated Interface between Access Health CT and ImpaCT.[17]

Current service requirements in the Money Follows the Person Program reflects a reduction in funding of $5,867,987 in FY 16 and $11,256,024 in FY 17.[18]

Medicaid funding is reduced by $4.3 million in FY 16 and $5.1 million to reflect lower payments associated with ambulance services (See sections: 388 and 389 of PA 15-5 JSS; a budget implementer).[19]

Pharmacy reimbursement rates are reduced by $2,150,000 in FY 16 and $2,250,000 in FY 17, reflecting an increase in the discount rate from Average Wholesale Price (AWP) minus 16% to AWP minus 16.5% and reducing the dispensing fee from $1.70 to $1.40 per prescription. (See section: 381 of PA 15-5 JSS; a budget implementer). This is different than the Governor's original proposal which proposed reducing funding by $6.2 million in FY 16 and $6.8 million in FY 17, reflecting an increase in the discount rate from Average Wholesale Price (AWP) of minus 16% to AWP minus 18% and reducing the dispensing fee from $1.70 to $1.40 per prescription.[20]

Funding is reduced by $850,000 in FY 16 and FY 17 to reflect reducing the performance payments to ASO's to 6% of the contract amount and maintaining the Connecticut Home Care Program for Elders (CHPE) funding at $300,000 which was scheduled to increase to $500,000.[21]

* (*Note: The Governor's Budget originally reduced the Personal Needs Allowance (PNA) from $60 to $50 a month resulting in a reduction in funding of $1 million in FY 16 and FY 17. The Legislature maintained the funding and monthly amount of the PNA.*)

[16] Ibid., p.340
[17] Ibid., p.348
[18] Ibid., p.337
[19] Ibid., p.343
[20] Ibid., p.343
[21] Ibid., p.343

E. Eliminations

Scheduled rate increases for long-term care facilities are eliminated resulting in a reduction in funding of $6.9 million in FY 16 and $17.8 million in FY17 (See sections: 377 and 378 of PA 15-5 JSS; a budget implementer).[22]

Low cost hospital payments are eliminated resulting in a reduction in funding of $5,130.000 in FY 16 and FY 17. The Legislature stabilized this by creating a new small hospital pool which is funded $5 million in FY 16 and FY 17 (See section: 382 of PA 15-5 JSS; a budget implementer).[23]

Funding is reduced by $10.5 million in FY 16 and $15 million in FY 17 to reflect the elimination of the Duals Demonstration.[24]

* (*Note: The Governor's Budget originally reduced funding of $1,443,800 in FY 16 and $1,649,800 in FY 17 to reflect closing the Torrington Regional Office . The Legislature maintained the funding and operation of the Torrington Regional Office.*)

II. Executive Rescissions on Medicaid

A. Reduction in funding to DSS Medicaid Account

On September 18, 2015 the Office of Policy Management released a list of FY 16 budgetary recessions including a reduction of $63.5 million to the Department of Social Services' Medicaid account.[25] The final three fiscal quarterly installments for both the Medicaid Supplemental and Small Hospital Pool payments are eliminated under the reduction.

The Office of Fiscal Analysis provides a document outlining the payment eliminations and subsequent loss in matching federal funds at:
https://www.cga.ct.gov/ofa/Documents/year/OD/2016OD-20150918_September%20Rescission%20-%20Hospital%20Impact.pdf

[22] Ibid., p.345
[23] Ibid., p. 342
[24] Ibid., p. 345
[25] Office of Fiscal Analysis. Analysis of September 18, 2015 Governor's FY 16 Rescissions, *October 8, 2015*. https://www.cga.ct.gov/ofa/Documents/year/GA/2016GA-20151008_Analysis%20of%20September%2018,%202015%20Governor's%20FY%2016%20Rescissions.pdf

III. December Special Session

A. Reduction in funding to DSS Medicaid Account

Public Act No. 15-1, as passed by the legislature during the December Special Session, reduces the Medicaid account of the Department of Social Services by $34,161,186 in both the 2016 and 2017 fiscal years. $30 million of this is from reductions in the Medicaid supplemental payments to hospitals and assumes the Governor's September rescissions are undone (See Chart Below provided by OFA). $243,535 is reduced with an update to the Small Hospital Pool. The remaining reduction reflects adjustments in expenditures and is not related to specific policy change.

	Reduce Hospital Supplementals - DMP		Update Small Hospital Pool - Current		Combined Impact
BACKUS	($2,403,803)		$0		($2,403,803)
BRIDGEPORT	($9,137,507)		$0		($9,137,507)
BRISTOL	($1,377,944)		($1,267,703)		($2,645,647)
CCMC	$0		$0		$0
DANBURY	($3,753,443)		$0		($3,753,443)
DAY KIMBALL	($986,746)		($219,771)		($1,206,517)
DEMPSEY	$0		$0		$0
GREENWICH	($514,807)		$0		($514,807)
GRIFFIN	($850,166)		$733,765		($116,400)
HARTFORD	($10,257,270)		$0		($10,257,270)
HOSP. CEN. CT	($4,845,870)		$0		($4,845,870)
HUNGERFORD	($1,035,000)		($1,092,388)		($2,127,388)
JOHNSON	($395,807)		$1,099,712		$703,905
LAWRENCE & MEM	($3,279,535)		$0		($3,279,535)
MANCHESTER	($2,359,318)		$0		($2,359,318)
MIDSTATE	($2,596,619)		$0		($2,596,619)
MIDDLESEX	($2,196,364)		$0		($2,196,364)
MILFORD	($239,768)		$8,398		($231,371)
NORWALK	($3,183,516)		$0		($3,183,516)
ROCKVILLE	($442,325)		$0		($442,325)
ST FRANCIS	($10,257,270)		$0		($10,257,270)
ST MARYS	($4,447,200)		$0		($4,447,200)
ST VINCENTS	($6,979,176)		$0		($6,979,176)
SHARON	($168,128)		$0		($168,128)
STAMFORD	($3,900,820)		$0		($3,900,820)
WATERBURY	($4,200,555)		$0		($4,200,555)
WINDHAM	($842,863)		$0		($842,863)
YALE incl. ST RAPHAEL	($10,257,270)		$0		($10,257,270)
TOTAL HOSPITAL IMPACT	**($90,909,091)**		**($737,986)**		**($91,647,077)**

STATE BUDGET IMPACT	**$30,000,000**	**$243,535**	**$30,243,535**

IV. Initiatives

As is memorialized in the DSS Annual Report, as well as supporting documents including the "Precis of the Connecticut Medicaid Program", Connecticut Medicaid is employing diverse strategies to achieve improved coordination of care, care experience and health outcomes for approximately 720,000 members served by the program. It is through the following strategies, and not through cutting services, that the program is achieving cost savings:

1) use of an administrative services organization (ASO) platform to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services;
2) use of data analytics to improve care;
3) activities in support of improving access to preventative primary care (e.g. Person-Centered Medical Homes, primary care rate increase, Electronic Health Record funding);
4) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS)(e.g. Intensive Care Management [ICM], behavioral health homes, ;
5) initiatives designed to "re-balance" spending on LTSS (e.g. Money Follows the Person, nursing home "right-sizing"); and
6) efforts to promote the use of health information technology.

Please see the infographics that are included on the first two pages of this recently released document for an accessible summary of Connecticut Medicaid care coordination and practice transformation initiatives:

https://www.cga.ct.gov/med/committees/med1/2015/1118/20151118ATTACH_Medicaid%20integration%20and%20care%20coordination%20infographic%20and%20practice%20transformation%20chart%20-%20final%20copy.pdf

DSS' hypothesis is as follows:

Centralizing management of services for all Medicaid beneficiaries in self-insured, managed fee-for-service arrangements with Administrative Services Organizations, as well as use of predictive modeling tools and data to inform and to target beneficiaries in greatest need of assistance, will yield improved health outcomes and beneficiary experience, and will help to control the rate of increase in Medicaid spending.

This hypothesis is being proved out through improved results on a broad range of measures related to quality, care experience and access. It is also substantiated by the program's relatively constant overall expenditures and the fact that per member, per month costs are, as is illustrated on the graphs that are included later in this report, trending downward.

Additionally, under the Affordable Care Act, Connecticut Medicaid has been able to bring in extensive new federal resources that have offset state spending on Medicaid as well as enabling important new care delivery and payment reform work.

Connecticut Medicaid care coordination and revenue maximization efforts are described in more detail below.

A. Connecticut Medicaid Care Coordination Initiatives

Administrative Services Organization Initiatives

Structure. By contrast to almost all other states, Connecticut no longer utilizes managed care arrangements, under which companies receive capitated payments for serving beneficiaries. Instead, Connecticut Medicaid is structured as a self-insured, managed fee-for-service model, through which the program contracts with four statewide Administrative Services Organizations (ASOs), respectively, for medical, behavioral, and dental health and for non-emergency medical transportation (NEMT) services. A percentage of each ASO's administrative payments is withheld by the Department pending completion of each fiscal year. To earn back these withholds, each ASO must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction outcomes. An important feature of the ASO arrangement is that three of the ASOs provide Intensive Care Management (ICM), an intervention developed specifically to meet the diverse needs of our most socially and medically vulnerable members.

ASO arrangements have substantially improved beneficiary outcomes and experience through centralization and streamlining of the means of receiving support. The ASOs act as hubs for member support, location of providers, ICM, grievances and appeals. ASO arrangements have also improved engagement with providers, who now have a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid. Providers can bill every two weeks, and 'clean claims' are paid completely and promptly through a single fiscal intermediary – Hewlett Packard Enterprises. This promotes participation and retention of providers, as well as enabling monitoring of the adequacy of the networks needed to support a growing population of beneficiaries.

Data Analytics. Employing a single, fully integrated set of claims data, which spans all coverage groups and covered services, Connecticut Medicaid takes full advantage of data analytic tools to risk stratify beneficiaries and to connect those who are at high risk or who have complex health profiles with ASO ICM support. Risk stratification is based on medical and pharmacy claims, member/ provider records, and results from diagnostic laboratory and imaging studies. Factors used to determine risk include: 1) overall disease burden (ACGs); 2) disease markers (EDCs); 3) special markers (Hospital Dominant Conditions and Frailty); 4) medication patterns; 5) utilization patterns; and 6) age and gender.

Intensive Care Management (ICM). ICM is structured as a person-centered, goal directed intervention that is individualized to each beneficiary's needs. Connecticut Medicaid's ICM interventions:

- integrate behavioral health and medical interventions and supports through co-location of clinical staff of the medical and behavioral health ASOs;

- augment Connecticut Medicaid's Person-Centered Medical Home initiative, through which primary care practices receive financial and technical support towards practice transformation and continuous quality improvement;
- are directly embedded in the discharge processes of a number of Connecticut hospitals;
- sustain the reduction of emergency department usage, inpatient hospital admissions and readmission rates;
- reduce utilization in confined settings (psychiatric and inpatient detoxification days) among individuals with behavioral health conditions; and
- reduce use of the emergency department for dental care, and significantly increase utilization of preventative dental services by children.

Interventions through the medical ASO, CHN. CHN utilizes a stratification methodology to identify members who presently frequent the emergency department (ED) for primary care and non-urgent conditions as well as those at risk of future use of acute care services. High risk members are defined as those who have claims data of seven (7) or more ED visits in a rolling year; members with twenty (20) or more ED visits in a rolling year are defined as ED Super Users and are considered highest risk. ICM focuses on high risk members with multiple co-morbid, advanced, interrelated, chronic and/or behavioral (psychiatric and/or substance abuse) conditions. These members frequently exhibit instability in health status due to fragmented care among multiple providers, episodes or exacerbations and/or complications and impaired social, economic and material resources and tend to have higher ED utilization. Many of these members are homeless and are in need of coordinated housing and access to health homes. Individuals with multiple chronic conditions benefit from an integrated plan of care that incorporates behavioral and non-medical supportive services.

Interventions through the behavioral health ASO, ValueOptions. ValueOptions used claims and other data to identify the five Connecticut hospitals that were associated with the greatest number of Medicaid high utilizers. ValueOptions then designed and implemented a multi-pronged approach to reduce the inappropriate use of the emergency department for individuals with behavioral health conditions. This approach includes 1) assigning ICM to individuals who have visited the ED, with a primary or secondary behavioral health diagnosis, seven or more times in the six months prior to participation in ICM; 2) assigning peer specialists to members who could benefit from that support; and 3) dedicating a Regional Network Manager to help facilitate all-provider meetings to address the clinical and social support needs of the involved individuals. These provider meetings are multi-disciplinary and include, but are not limited to, representatives from housing organizations, substance abuse and mental health providers, shelters, Federally Qualified Health Centers, and staff from the respective EDs.

Interventions through the dental health ASO, BeneCare. Care Coordination and Case Management services are provided through a team of seven Dental Health Care Specialists (DHCS) who are unique to Connecticut; six of whom who cover specific regions and one of whom works with clients who have Special Health Care Needs (SCSHCN). Professionals or

community agencies can refer identified clients to the CTDHP for care coordination services. Services include management of care and coordination of services between dental and medical specialties as well as the coordination of other Medicaid benefits. Special outreach initiatives are focused on educating the population about oral health care and include prenatal clients, children who do not have routine care, clients with special health care needs, sealant placement to prevent future decay and improved dietary choices including encouraging responsible behaviors.

Results of Connecticut Medicaid's care coordination and ICM interventions have been striking.

Over SFY'15, through a range of strategies (Intensive Care Management, behavioral health community care teams) and in cooperation with the Connecticut Hospital Association, **the Emergency Department visit rate was reduced** by:

- 4.70% for HUSKY A and B
- 2.16% for HUSKY C
- 23.51% for HUSKY D

Over SFY'15:

- Overall admissions per 1,000 member months (MM) **decreased by 13.2%**
- Utilization per 1,000 MM for emergent medical visits **decreased by 5.4%**
- Utilization per 1,000 MM for all other hospital outpatient services **decreased by 5.3%**

Over SFY'15. Connecticut Medicaid's medical ASO, CHNCT, has:

- for those members who received ICM, **reduced emergency department (ED) usage** by **22.72%** and **reduced inpatient admissions by 43.87%**
- for those members who received Intensive Discharge Care Management (IDCM) services, **reduced readmission rates by 28.08%**

Based on the strength of its ICM strategies, and extensive data capability, the Connecticut Medicaid program was in SFY'15 selected to participate in a year-long "policy academy" convened by the National Governor's Association, in support of further enhancing supports for high need, high cost beneficiaries ("super utilizers").

Person-Centered Medical Home Initiative (PCMH). The Connecticut Medicaid PCMH program aims to enable comprehensive primary care for children, youth and adults through 1) partnerships between individuals and their personal physicians; 2) a whole person approach to providing and coordinating care; 3) systematic performance of quality improvement activities with a focus on patient safety; and 4) enhanced access to care through improved scheduling and communication. Under the PCMH initiative:

- 101 practices (affiliated with 366 sites and 1,332 providers) are participating;
- over 274,000 beneficiaries are being served; and
- in 2013, eligible practices received an average of $121,000 in enhanced payments, $6,000 in incentive payments and $13,900 in improvement payments.

PCMH practices have achieved better results than non-PCMH practices on measures including, but not limited to adolescent well care, ambulatory ED visits, asthma ED visits, LDL screening, readmissions and well child visits. Practices achieved an **overall member satisfaction** rating of 91.1% among adults and 96.1% on behalf of children. **Immediate access to care increased** to 92.5% of the time, when requested by adults, and 96.7% of the time, when requested on behalf of children. Among a number of **measures of courtesy and respect** shown to HUSKY members, communication before and during care, PCMH providers were rated overwhelmingly positively by HUSKY members.

B. Federal Revenue Maximization

Connecticut Medicaid has also sought and received extensive new federal resources under the Affordable Care Act (ACA). These resources have:

- enabled many new people to access coverage under expansion of Medicaid eligibility – participation in HUSKY D, our Medicaid expansion group, increased from **99,103** individuals in December 2013 to **180,401** individuals in October 2015.

    ➔ *Research shows that coverage gives people more financial security from the catastrophic costs of a serious health condition, tends to improve mental health, and enables earlier diagnosis of conditions such as diabetes.*

- permitted Connecticut Medicaid to cover new services that are of great benefit to Medicaid beneficiaries – just one example is coverage of tobacco cessation services (counseling, treatment and medications)

    ➔ *This is a well targeted service because many sources estimate that far more Medicaid beneficiaries smoke than is typical of the general population.*

- provided new family planning services for eligible individuals

    ➔ *Family planning services support women and men in good reproductive health, and helps reduce unintended pregnancies, which in turns promotes better long-term health, completion of education and improved outcomes of subsequent pregnancies.*

- expanded the highly successful Money Follows the Person program, which supports individuals in transitioning from nursing facilities to living in the community

    ➔ *MFP has supported over 3,000 individuals with disabilities and older adults in moving from nursing facilities to their setting of choice.*

- provided $83.5 million in resources under the State Balancing Incentive Program that will help support Medicaid beneficiaries in accessing home and community-based long-term services and supports

    ➔ These new resources will help to address the historical imbalance of LTSS resources as between nursing facilities and home and community-based services.

- enabled the DMHAS-led behavioral health, health home effort

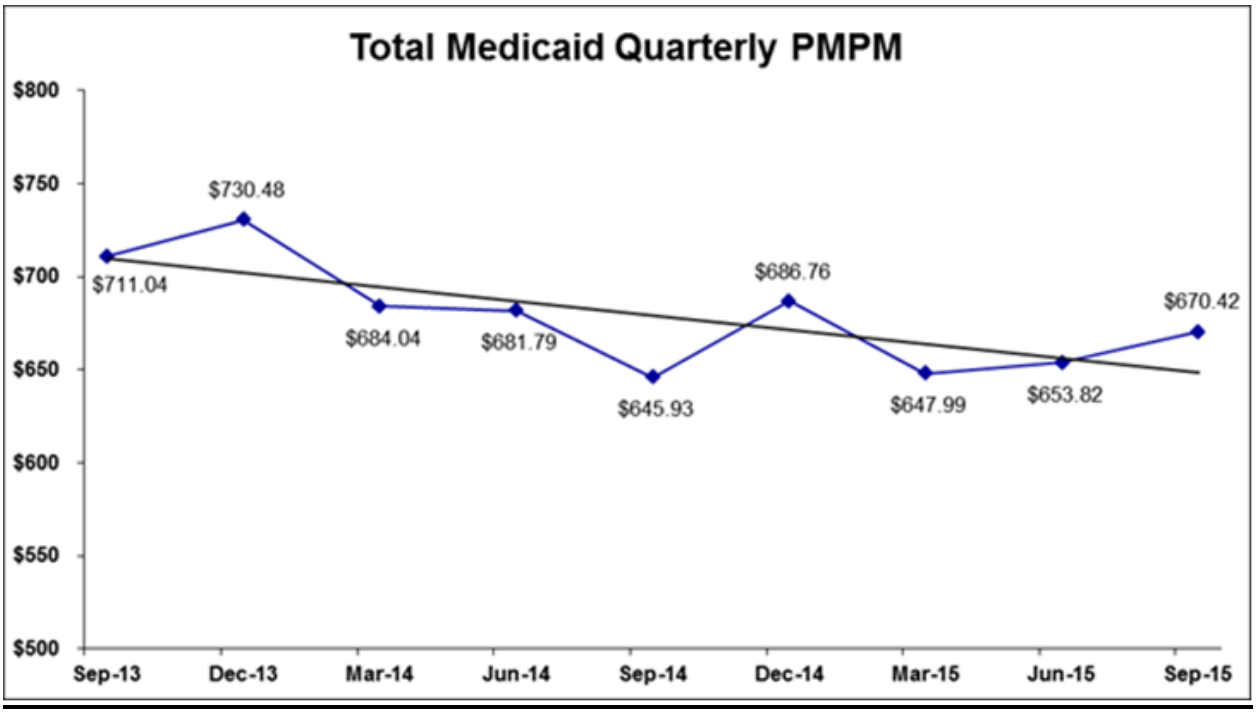
➔ *Health homes will enable local mental health authorities and their affiliates to integrate behavioral health, primary care and community-based supports for people with Serious and Persistent Mental Illness.*

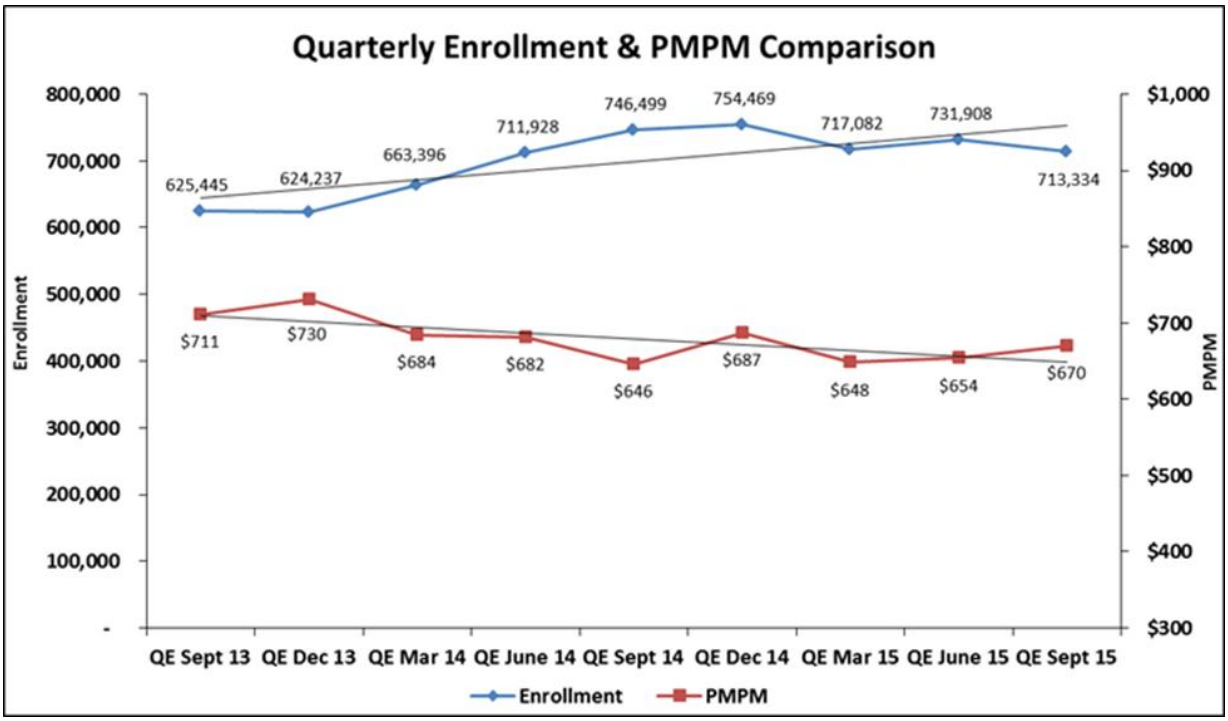
- funded rate increases that increased participation of primary care practitioners in Medicaid from 1,622 on January 1, 2012 to 3,589 on January 1, 2015

➔ Access to primary care is a key aspect of Medicaid reform and an essential means of reducing use of the emergency department as well as effective management of chronic conditions.

V. Medicaid Expenditures

The Department of Social Services has provided the following graphs that reflect expenditures in the Medicaid Program. The Medical Assistance Program Oversight Council anticipates a more extensive report on expenditures at the beginning of 2016.




Quarterly Enrollment & PMPM Comparison
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
-
Enrollment
$1,000
$900
$800
$700
$600
$500
$400
$300
PMPM
625,445
624,237
663,396
711,928
746,499
754,469
717,082
731,908
713,334
$711
$730
$684
$682
$646
$687
$648
$654
$670
QE Sept 13
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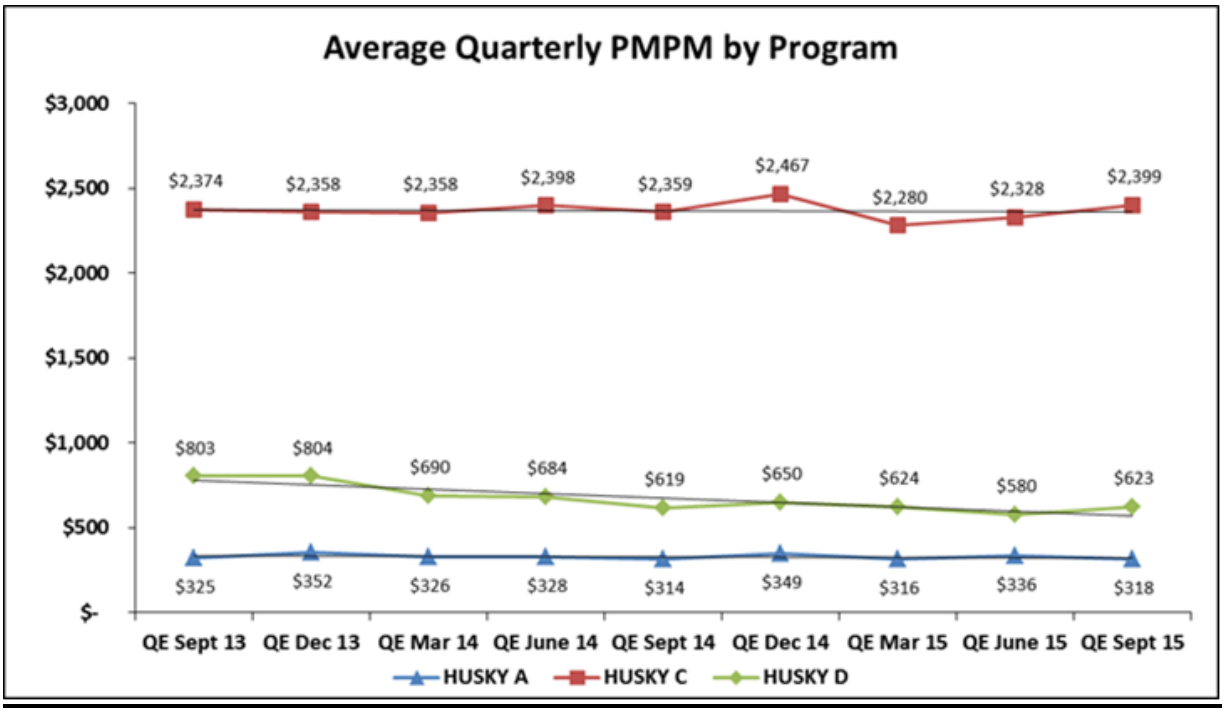
QE Sept 14
QE Dec 14
QE Mar 15
QE June 15
QE Sept 15
Enrollment
PMPM


Average Quarterly PMPM by Program
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$-
$2,374
$2,358
$2,358
$2,398
$2,359
$2,467
$2,280
$2,328
$2,399
$803
$804
$690
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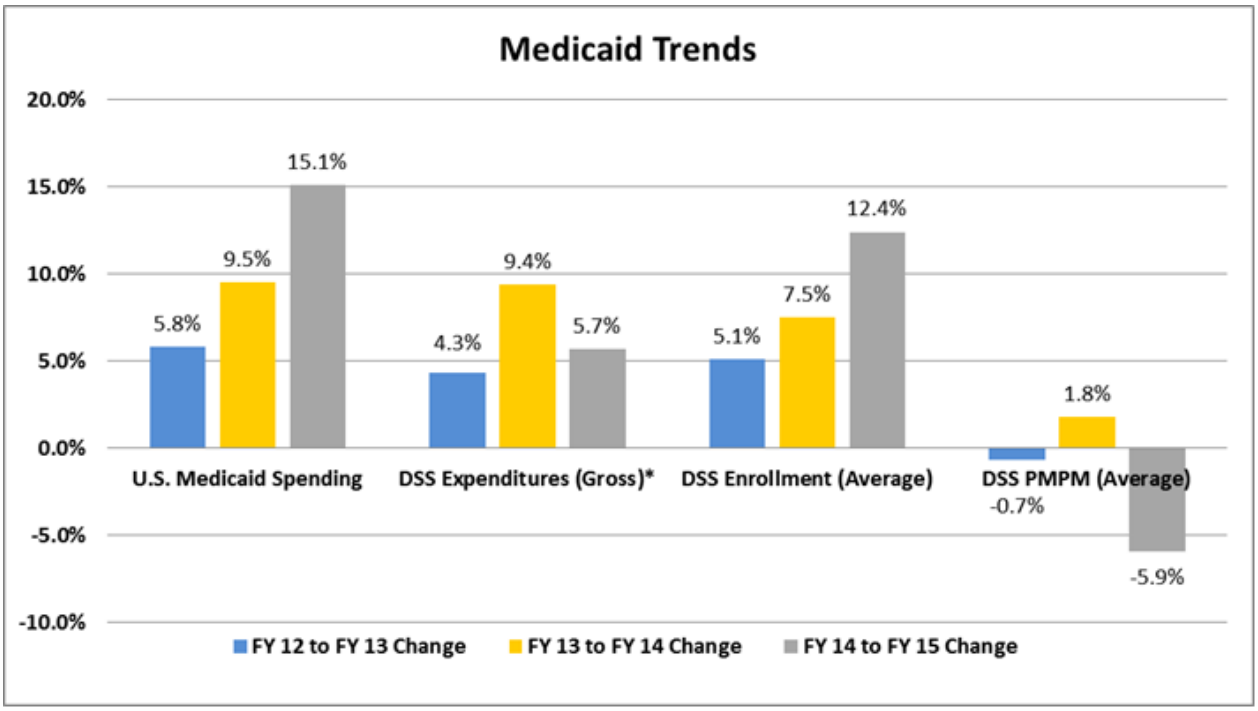
QE June 15
QE Sept 15
HUSKY A
HUSKY C
HUSKY D



Richard Eighme
Council Clerk

2016 Agenda Items

- As required under Statute, The Department of Social Services shall continue to provide monthly reports to the council on the matters described in subsection (e) of Sec. 17b-28.
- The Council will continue to receive reports from DSS and Access Health CT on the transition of Husky A adults as required under Public Act No. 15-5.
- The Council will receive monthly reports from its subcommittees.
- Receive an update from the WIC Program and Federal funding for EBT.
- Receive an update on DMHAS Behavioral Health Homes.
- Receive updates on Access Health CT enrollment and automated interface system.
- Receive updates on the Behavioral Health Partnership.
- Receive updates on Non-Emergency Medical Transportation.
- Receive updates on the Dental Health Partnership.
- Continue to receive and review reports on the Husky Program from CT Voices for Children.
- The Cost Savings Subcommittee will report to the full Council as required under Section 17b-28 (h) of the Connecticut General Statutes.
- The Care Management Committee will continue to provide oversight and input on the development and implementation of the Medicaid Quality Improvement and Shared Savings Program (MQISSP). The Council will receive quarterly updates on the initiative.
- The Care Management Committee will continue to receive bi-monthly reports on Person Center Medical Home (PCMH).
- The Complex Care Committee will monitor the state's participation in the National Governor's Association's, High Need High Cost Policy Academy. The Council will receive quarterly updates on the academy.
- On and after July 1, 2016, as amended by section 1 of public act 14-62, Sec. 17b-261m; ASO's with access to complete client claim adjudicated history are required to analyze and annually report to MAPOC on Medicaid clients' use of hospital emergency departments.
- The Women's Health Committee will continue to study women's health in the Medicaid program; including infants and children.
- The Consumer Access Committee will continue to meet jointly with the Coordination of Care subcommittee (BHPOC) and review grievance reports within the Husky Program and study issues with access to care.
- The Chairs will tour (a) DSS field office(s) and ASO's Connecticut offices to get a more comprehensive analysis of Medicaid related operations.

Appendix A

MEETING MINUTES

Friday, April 10, 2015

9:30 AM in Room 1E of the LOB

I. The meeting was called to order at 9:36 PM by the Chair, Representative Abercrombie.

The Chair thanked everyone for their attendance and announced that Sen. Gerratana, the Co-Chair, would be late due to a Judiciary Meeting the evening before.

Introductions were made by Council Members and agency personnel.

II. Kate McEvoy of the Department of Social Services (DSS) introduced her colleges who would be giving a presentation on the Department's eligibility and enrollment; which included an update on ConneCT. The presentation consisted of three parts, including the past state of DSS, the current state and the future state. (See Attachment)

http://cga.ct.gov/med/council/2015/0410/20150410ATTACH_DSS%20Presentation%20.pdf

Rep. Abercrombie thanked DSS for their presentation, expressing her pleasure with the direction the Department is heading. She questioned the hiring of a consultant and what the status was.

Roderick Bremby, The Commissioner of DSS, explained the Department's dedication to always improving itself. He explained a conflict in Terracore that needed advisement. The Commissioner discussed the reduction in functionality and relationship to reduction in wait times.

Deb Polun, of CHCACT, requested more information on the Lifeline negotiations.

DSS explained how the program currently works and the programming that needs to be done moving forward.

Mary Alice Lee of CT Voices for Children offered a comment to DSS.

Commissioner Brembly expressed appreciation of the comment and added the DSS was working on being more personable with the people it serves.

Sylvia Kelly shared her pleasure with DSS's presentation.

Jane McNicol, present on behalf of Kristen Hatcher, asked several questions about document processing, Terracore and households served.

DSS responded that many documents sit in a Queue and processing can be as simple as verification. Though Terracore is only related to SNAP, benefit centers answer all calls. DSS does not have a set target of households, though the more served the better. The Commissioner added that they are just getting started.

Matthew Barrett of The CT Association of Health Care facilities asked a question about eligibility and reapplications.

DSS responded that they had specific people to handle reapplications and that while there was an increase in the beginning, things have leveled out.

Kathy Yacavone of SWCHC, asked if the Impact and Online rollouts were together or separate and for a better understanding of redetermination and reenrollment.

DSS explained that they hoped both would begin being implemented in 2016 and that Impact was there priority. Kristen Douty explained the reenrollment process and verification of eligibility.

Stephen Frayne of CHA asked a question pertaining to wait time and customer service.

DSS responded that Terracore was in the assessment phase and once completed would provide better information on processing and wait times.

Rev. Bonita Grubbs expressed pleasure that wait times had dropped but added they needed to drop more.

DSS added that Terracore's report would help to make improvements.

Jeffery Walter asked for a definition of timeliness and questioned process improvement of completed vs. not completed applications. He stressed the need for focus on online resources.

DSS explained the time frame established by the Federal Government and agreed with a focus on online applications. They added however, that some populations need phone or in person options and that Terracore will help the Department see where it needs improvements.

Rep. Srinivasan asked for clarification on the wait time slide of the presentation.

Rep. Johnson thanked DSS for their presentation and the information provided.

Mary Alice Lee offered a recommendation to DSS and Access Health.

Rep. Abercrombie requested a presentation from Access Health CT on enrollment.

Deb Polun agreed with Rep. Abercrombie and the existence of a disconnect between Access Health and DSS. She questioned staffing levels.

DSS responded that its current staffing level is around 215, though the number fluctuates. There are around 300 physical agents that can staff the benefit centers, but DSS is limited by space and contractual obligations. The ideal number of staff would be all 300 agents.

Kristin Douty of DSS, explained the process of Medicaid enrollment.

Discussion followed between Council Members, Xerox, DSS and Access Health CT as to issues facing information processing and auto-renewal. Steve MacKinnon of Xerox added that being accurate and vetting information prevents further issues in the future.

Jesse White-Frese asked, as a provider, how to best prepare people to deal with DSS as efficiently and effectively as possible.

DSS explained the necessary documentation to apply for Medical Assistance and distinguished between in-person, over the phone and online applications.

Mary Alice Lee questioned the information process and why Xerox had to do research.

Discussion followed between Council Members, Xerox, DSS and Access Health CT as to the accuracy of information and defects in the technical design of the processing system.

Rep. Abercrombie reiterated a request for a presentation from Access Health CT adding she would talk to Sen. Gerratana. She thanked the Council for their questions.

III. Deb Polun and Ellen Andrews, on behalf of the Complex Care Committee, offered the Committee's recommendations on the Dually Eligible Pilot Program. They explained that in the Governor's budget, funding for the program had been removed. The removal of such funding would halt progress and make past work wasteful. The program could lead to cost savings and better health care to those dually eligible for Medicare and Medicaid. They asked for a consensus of support from the council. (See Attachment)

http://cga.ct.gov/med/mh-meetings.asp?sYear=2015

Sen. Gerratana opened the floor to questions and comments.

Ellen Andrews added details about the funding of the program.

Matthew Barrett offered his opinion on the 3 day hospital stay requirement and how better coordination could lead to significant savings.

DSS explained that they are working with CMS on the impact of expenses.

Ellen Andrews added they believed the program could lead to massive savings. She explained that kit was not a done deal and that there were a lot of challenges ahead.

Jesse White-Frese requested clarification on the justification of the statement.

Mag Morelli offered her support of the recommendation, and expressed frustration with the Budget.

Stephen Frayne concurred and asked the committee give its support.

Sen. Gerratana added the recommendation seemed to have the full support of the council. She talked about the restoration and the budget.

Rep. Abercrombie added that Human Services was taking a significant hit in the Governor's budget and that the process was on going and difficult. She requested that members contact their State Legislators and express their concerns with the budget.

Sen. Gerratana stated a letter would be drafted and sent to legislative leadership on behalf of MAPOC, expressing the council's recommendation on the Dually Eligible Pilot Program.

IV. No Committee Updates were presented.

V. Kathy Yacavone offered a brief follow up on proposed eligibility cuts.

Sen. Gerratana and Rep. Abercrombie welcomed the new Council Clerk, Rich Eighme.

Kate McEvoy shared DSS's pleasure in the work and continuation of work the Department would do with the new Clerk.

Rep. Abercrombie shared the reported absentees of Council members.

The next meeting will be held on **Friday, May 8, 2015 at 9:30 AM.**

The meeting was adjourned at 11:48 AM.

MEETING MINUTES

Friday, May 8, 2015

9:30 AM in Room 1E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:35 PM by the Chair, Representative Abercrombie.

She thanked members for their presence and shared the reported absentees of the Council, including Co-Chair, Senator Gerratana.

Introductions were made by Council Members and Agency Personnel.

II. Marjorie Chambers, the WIC Program Director of the Department of Public Health (DPH), introduced herself and colleagues who would be presenting an overview of the Connecticut WIC Program (See Attachment). The presentation began with an overview of the background and structure of the Program. It continued with information on who is served and eligible for the program, as well as its locations and infrastructure. Marjorie went over the program's financial implications which are used towards services which cover the following outcome objectives: maternal weight gain, low birth weight, breast feeding, anemia, overweight and obesity.

Kimberly Boulette talked about the Food Resources and Vendor Management Division of WIC. Federal grant money is on the way and the program will be integrated into EBT giving more flexibility and financial information.

Marjorie Chambers finished the presentation by talking about the coordination with state and local agencies and the general benefits of participating in the program.

http://cgalites/med/council/2015/0508/20150508ATTACH_WIC%20Program%20Presentation.pdf

Rep. Abercrombie thanked the Program for their presentation and asked how close they were to establishing a MOU of information sharing with the Department of Social Services (DSS).

Dr. Zavoski of DSS responded that they were very close and explained the challenges in establishing such a data sharing process.

Rep. Abercrombie asked for further detail on the Baby Friendly Hospital Initiative.

Marjorie Chambers explained the support and encouragement the program gives and what qualifies a "Baby Friendly Hospital." Renee Coleman-Mitchell added some historical background of the initiative.

Amy Gagliardi added that she was happy to hear that currently 15 of all the birthing hospitals are Baby Friendly which is half of the birthing hospitals.

Dr. Zavoski discussed the cost associated with being a baby friendly hospital and the commendation these hospitals deserve.

Katherine Yacavone expressed her opinion from a subcontractor perspective and the partnership the program entails. She gave her praise to the program and stated she looks forward to the convenience of EBT.

Dr. Zavoski extended his appreciation of the program and the very important things it accomplishes.

Deb Polun asked a question about the MOU and if the data sharing would go in the other direction by automatically enrolling women in the SNAP Program.

Marjorie responded that they had not looked into that but certainly would.

Dr. Zavoski responded that DSS would be happy to share data as such, and that it would be much easier to do once Impact is up and running, which will replace DSS's current, outdated information system.

Marjorie added that asking a participant if they are already registered in SNAP is mandated.

Reverend Bonita Grubbs asked how change would be measured over time.

Marjorie explained that there are monthly reports created that contain specific data which is passed on to the USDA and presented on a national and state level and then divided locally.

Renee Coleman-Mitchell explained that she had recently been working with a grant dealing with Head Start which would give more data displaying the benefits of WIC.

Marjorie added that with the new system WIC will be able to get more detailed reporting.

Rep. Abercrombie agreed with Rev. Grubbs recommendation that a follow up presentation be given in the future by WIC after the implementation of the new system.

Beth Cheney reiterated Dr. Zavoski's comments saying the program is one of the best she has ever worked with.

Commissioner Betsy Ritter asked about SNAP and situations where seniors are living together and expressed her concern with the participation in the program by the elderly.

Marjorie responded that they are mandated federally to serve a specific population.

Discussion followed between the Commissioner and Dr. Zavoski about the capturing of elderly people and the messaging used for the take up of participants.

Rep. Johnson thanked the program for their presentation and asked if the work being done with baby friendly hospitals was being done with obstetricians.

Marjorie responded that the work was being done closely between the two and that the gap from several years ago has been identified and alleviated.

Renee Coleman-Mitchell added that a mass mailing had been sent recently to providers giving information on the program and its benefits.

III. James Michel gave a presentation on the enrollment process of Access Health CT (See Attachment). He began by explaining how to enroll; either via the web, in person, by telephone or through a paper application, and the path which an enrollee would then follow based on the information provided.

http://cgalites/med/council/2015/0508/20150508ATTACH_Access%20Health%20CT%20-%20Call%20Center%20Presentation%20.pdf

Rep. Johnson asked for clarification on the billing part.

The presentation continued with an overview of the structure of the call centers and it's Interactive Voice Response between AHCT, DSS, OHA, CID and Health Insurance Carriers.

Mary Alice Lee asked if when a call is referred to DSS, if that was specifically to ConneCT.

James Michel explained the difference between a warm transfer (AHCT rep. on-phone) and standard call transfers.

Rep. Johnson questioned the coordination between DSS and Access Health and the systems and integration used.

Kristin Dowty explained the application system that is used by the different agencies and the process to which it is implemented. They hope to have the new system partially running in the spring of next year.

Sheila Amdur asked about Husky C which Kristen explained is covered by a prompt in the application process.

Deborah Poerio added that she hoped receiving payments for School based Health Centers would be incorporated in the new system.

James Michel proceeded with the presentation, showing the total number of processed applications by month and type and the different programs.

Ellen Andrews asked for clarification on the slide. The data only reflects enrollment through the Access Health System.

IV. Dr. Zavoski requested that Logisticare present next month due to a scheduling conflict. Rep. Abercrombie agreed and moved to the second DSS presentation from Value Options.

The two presenters introduced themselves as Scott Greco, the Director of Provider Relations and Marie Betvila a Peer Support Specialist. They began with an overview of the CT

Behavioral Health Partnership call center and the process of member referrals (See Attachment).

http://cgalites/med/council/2015/0508/20150508ATTACH_Value%20Options%20Member%20Resources%20Presentation.pdf

Rep. Johnson received clarification on what defines a member.

Scott and Marie walked through the Referral Connect program which links members to providers.

Katherine Yacavone asked how a member would get the displayed information if they did not have a computer and by what basis were Community Health Centers listed.

Scott stated that at the facility level they do not list individual practitioners. He explained that due to confidentiality, outreach to members can be difficult but they do receive information from DSS and partners of Behavioral Health. By calling directly, members can be walked through the website, and there are also phone applications available.

Deborah Poerio stated her pleasure with the provider page and asked if there were focus groups.

Scott explained the process of developing the website and what was done to improve it. Ann Phelan of Value Options added that there was a consumer advisory group that met monthly to go over any changes and improvements to the website.

Beth Cheney wanted to know what she could tell her patients as a provider about the website and if there was a way to connect providers to each other.

Scott explained that calls are initially funneled through the customer service department which generally answers within 8 seconds. They are then directed based on the nature of the call. Peer referral can be used where they will talk to a "peer" who will work with the member to solve their issue. He added that adding a way for providers to gain information on their patients was a possibility.

Julia Evans Starr asked about the time of answering calls. Marie explained the customer service department and calling process and why it is efficient.

Deb Polun felt it would be useful to have data on the call centers of Value Options, Dental Health, CHN, DSS and Access Health CT.

Ivan Jones from Value Options explained the staffing levels and training and how the information on calls received might not be comparable.

Dr. Zavoski explained how different the call centers were between DSS and Value Options were including the outdated system, different circumstances and amounts of time needed to direct and process calls.

Katherine Yacavone asked that considering there is no prior authorization process under Medicaid if it could be explained that providers go through another process.

Scott explained the program, provider connect, which is an online process for requesting outpatient authorizations.

The Presentation continued with a demonstration of Achieve Solutions which is an online database of information and resources on behavioral health care.

Katherine Yacavone asked about the links to providers based on the information provided on a particular topic. Scott replied that it was done general enough to direct someone without giving a diagnosis.

Beth Cheney asked for further explanation on the peer services. Marie explained the service where people are linked with a person who is qualified to talk to members on a particular issue. She added that she couldn't say enough about the program and how useful and helpful it was.

Rep. Abercrombie felt the program was amazing and felt the website was very user friendly. She explained her excitement in the ASD portion and thanked Value Options. She believed it was important and nice to see that there are areas in which we can really help people.

Rep. Johnson reiterated a thank you to Value Options.

Scott added that it is important to help people enrich their lives and that Value Options is dedicated to that mission and staff believes in what they do.

Amy Gagliardi thanked the presenters and added that peer support is an invaluable component.

Dr. Zavoski thanked the presenters and explained the goal of these presentations and the positive direction the Medicaid program is continuing to move in.

Rep. Abercrombie talked about how in many cases the Council focuses on the negative aspects of the Medicaid program and improving it. She added that it was nice to end with a presentation that shows some of the more positive sides where people are able to receive help and better their lives.

V. Sheila Amdur explained what the Complex Care Committee would now be looking towards in the future and how the Value Options presentation tied in nicely to the issues the sub-committee would be reviewing, including substance abuse and mental health issues, which are populations of high utilizers of the State's Medicaid program. The next meeting will be on June 19th.

Rep. Abercrombie added that being on the Appropriations Committee, she had not been able to discuss the budget in detail and that with the dually eligible initiative, the Complex Care Committee had been reviewing, DSS needed to be thanked for reaching out to the Legislature and being flexible on the funding; ultimately returning the program to the Appropriations budget.

Amy Gagliardi stated that there would be a meeting of the Women's health Committee on Monday and discussed some of the issues that would be discussed including the proper care of birth outcome with a presentation on OB services and churning. The meeting would be at 9:30AM in Hearing Room 1A.

Rep. Johnson added that a bill which had just passed the house might want to be looked at by the subcommittee.

Beth Cheney shared a story about a patient who had recently enrolled in Husky Health Care, and his very positive and enlightening experience.

VII. Rep. Abercrombie asked if there were topics that the Council would like to review at the next meeting in addition to the Logisticare Presentation.

Deb Polun asked for an update on SIM and the QISSP program which were importantly tied into Medicaid.

Rep. Abercrombie asked Dr. Zavoski if DSS would be comfortable presenting on SIM and QISSP at the next meeting. He responded that they would be meeting next Wednesday on MQISSP with the Care Management Committee and that with the support of the chairs would be working on the many aspects of implementing the program.

Rep. Abercrombie found that it would be appropriate to have such a presentation at the next meeting to get an update on where the program is, where it is going, and where it needs to be and what the timeframe is.

Tracy Wodatch announced The 2015 Better Health Conference which would be sponsored by the CT Partners for Health. The Conference would be held on June 4th and 5th at Foxwoods Resort Casino, and information would be distributed to the Council to share with others.

With no other questions or comments, Rep. Abercrombie thanked all the presenters and members and commented on the insightfulness of the meeting.

The meeting was adjourned at 11:54 AM.

The next meeting will be held on **Friday, June 12, 2015 at 9:30 AM**

MEETING MINUTES

Friday, June 12, 2015

9:30 AM in Room 1E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:35 PM by the Chair, Sen. Gerratana.

Introductions were made by Council Members and Agency Personnel.

II. Kate McEvoy started DSS's presentation with a preview of what next month's meeting would comprise of.

Kate went over the 3 main elements of health care reform in Medicaid and emphasized why integration was so important. She explained that she would share the context, structure and detail of the initiatives and how CT is unique in its approach to being person centered. Kate gave details on the work of integration the Department, other agencies and organizations are currently performing.

Sen. Gerratana asked Kate to explain how the integrated models interact with a person. Kate deferred to Sylvia Kelly, from CHN, who went over the Intensive Care Program and how it works with health care recipients. Sen. Gerratana and Sylvia started conversation on the plans that are established to address the needs of individuals.

Dr. Zavoski explained the importance of ICM and the text messages that are sent with the help from federal funds that seeks to prevent and manage problems now, to have benefits in the future.

Suzanne Lagarde asked if there were any clear points that a provider could use to identify who would qualify for the program benefits. Sylvia Kelly explained how people qualify and receive the benefits of the program. Dr. Zavoski added that the provider should make the referral because the protocol is to except the referral.

Sen. Gerratana received information on contacting specific ASO's. Deb Poerio asked how applicable the services were for children.

Sheila suggested that the council move on to the integrated efforts because the complex care committee would be covering more complex and high utilization health care issues at future meetings.

Ellen Andrews discussed that there is a lot of information out there and that it might be valuable to recirculate it to help members.

Dr. Geertsma talked about the including of a primary care physician in the process and the relationship that is shared with a patient.

Amy Gagliardi asked Sylvia about the care coordination model and reaching out to high risk patients. Sylvia explained the challenges of getting in touch with those considered high risk and what CHN does to contact them. Amy asked to talk later about more information.

Kate McEvoy expressed appreciation in being guided by the Council and Sheila's comments on complex care issues. She continued with an overview on the Affordable Care Act and its impacts on Medicare and opportunities it offers. Kate then gave an overview and walked through the materials presented, including an infographic:

http://cga.ct.gov/med/council/2015/0612/20150612ATTACH_Medicaid%20integration%20projects%20infographic%205-10-15.pdf

And documents referring and giving details on the integration projects:

http://cga.ct.gov/med/council/2015/0612/20150612ATTACH_Medicaid%20integration%20projects%20short%20form%20comparison%20chart%205-10-15.pdf

http://cga.ct.gov/med/council/2015/0612/20150612ATTACH_Medicaid%20integration%20projects%20detailed%20comparison%20chart%205-10-15.pdf

http://cga.ct.gov/med/council/2015/0612/20150612ATTACH_A%20Brief%20Primer%20on%20MQISSP%205-10-15.pdf

Colleen Harington talked about Behavioral Health Homes and the work DMHAS is doing on the integration project. She went over some important facts that were not included in the documents provided.

Jeff Walter asked about eligibly for the health homes and PCP identifiers and coordination. Colleen responded that the homes would not be giving primary care but rather making sure individuals have such and get a primary care physician if they don't.

Sheila expressed her concern that these homes do not cover some of the most needy metal health individuals and asked about the outreach of the program. Kate and Colleen discussed Sheila's comment and question.

Ellen Andrews asked for clarification on the start date and talked about a webinar that would be happening on June 22nd.

Matt Barrett asked about a bill that would eliminate the details in contracts with ASO's regarding ICMs. Kate explained that the provisions were started in a law that was put into place last year following a report from PRI. DSS advocated that these provisions should be revised.

Kate continued by moving to the duals demonstration and acknowledged Rep. Johnson and Sheila Amdur who have advocated for the work they have done on the program. She provided an overview and update on the initiative.

Rep. Johnson thanked Kate and Sheila for their work on the project. Sheila talked about the process and its importance and discussed the future of the complex care committee. Sen.

Gerratana asked if Complex Care could give the Council an update of their work at future meetings.

Stephen Frayne asked how those deemed as dually eligible had changed over the years and how many persons would be impacted by the current model 1 only approach. Kate went over the current numbers and how they have changed.

Kate moved to the third integration project, MQISSP and went over the work that had been going on within the Care Management Committee. She explained the history of the program. Ellen discussed MQISSP and what the Care Management Committee has been reviewing. Sheila asked for more clarification on some of the aspects of MQISSP.

Dr. Geertsma asked if there was a provider workforce analysis in the state and discussed the focus of Medicaid savings on adults. Kate discussed Dr. Geertsma's concerns.

Katherine Yacavone asked Kate for clarification on the timing of the program.

Rep. Johnson followed up with Dr. Geertsma's comments and asked Kate about the broad future of Medicaid.

Matt Barrett asked a question for a better understanding of the organizational model for ICM's.

Kate thanked the Council and referred to the materials being posted on the website from the Care Management Committee.

III.

Future Subcommittee meetings were discussed.

IV.

With no other business, Sen. Gerratana thanked all the presenters and members.

The meeting was adjourned at 11:54 AM.

The next meeting will be held on **Friday, July 10, 2015 at 9:30 AM**

Richard Eighme
Council Clerk

Appendix B

MEETING MINUTES

Friday, July 10, 2015

9:30 AM in Room 1E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:49 PM by the Chair, Rep. Abercrombie.

Introductions were made by Council Members and Agency Personnel.

IIA. Personnel from DSS gave a presentation on Benefit Center Enrollment and Eligibility (See Attachment).
http://cga.ct.gov/med/council/2015/0710/20150710ATTACH_BCMAPOC%20July%202015.pdf

Rep. Abercrombie thanked the Department for their presentation and opened the floor to questions.

Molly Rees Gavin asked if there was a target goal for some of the numbers provided and if percent's of cases being completed were being monitored.

Rev. Grubbs asked about the changes DSS had implicated and the strategies that were being used.

Ellen Andrews asked if the numbers were sustainable and how DSS planned to keep them maintained.

Matthew Barrett asked about the CT Career Trainees.

Rep. Abercrombie asked how employees answering the phone help adults affected by the Medicaid cuts passed in the state budget. Mark Shok from DSS explained the 12 months of transitional medical assistance many would qualify for and notice that would be sent to them. For the smaller number of recipients who do not have earnings and would be losing coverage, a process was being established to get additional information to find what else they are eligible for. He added that while the cuts are effective August 1st recipients would continue to receive their benefits through the month of August. Kate explained the role the Office of the Health Care Advocate was playing in the process.

Rev. Grubbs shared a few of her concerns.

Deb Polun asked for further clarification on the transitional medical assistance program and shared her concern about the time for individuals to enroll.

Ellen Andrews asked what information is being shared. Demian Fentanella also discussed the information that was being submitted to DSS and the process involved. Discussion followed on individual's information, eligibility and transition to Access Health CT.

Rep. Abercrombie asked if the Council would like to have an update for the September Meeting. She thanked DSS for the work they have been doing and asked them to keep up the work. Deb asked that someone from Access Health be present in September to provide updates on the eligibility transition.

IIB. Kate McEvoy began by recognizing the many efforts from so many different people in the State's Medicaid Program. She announced the 50th Anniversary of Medicaid and gave an overview of what and why the social service is and how it was formed and shaped through videos on the web which included testimonials.

Rep. Abercrombie congratulated DSS for all their work and discussed the services in Medicaid Connecticut is able to provide.

III. Rep. Abercrombie shared that there was a PCMH meeting two days ago and explained her role in SIM.

IV. Rep. Abercrombie announced that there would not be an August Meeting. She asked that the next meeting be held on September 18th.

For the next meeting it was decided to have presentations on the completion rates for Medicaid Applications, information on the transition of Husky recipeients who no longer qualified for coverage and an update from Logisitcare.

With no other business, Rep. Abercrombie thanked all the presenters and members.

The meeting was adjourned at 11:03 AM.

The next meeting will be held on **Friday, September 18, 2015 at 9:30 AM**

MEETING MINUTES

Friday, September 18, 2015

9:30 AM in Room 1E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:34 by the chair, Sen. Gerratana.

***IV.** Sen. Gerratana went straight to item IV. A copy of the section of the implementer related to the required report, on Husky A Parents, was distributed. A letter was sent out by the Council Chairs asking the Department of Social Services and Access Health CT to share the required report at the November Council meeting.

Introductions were made by Council Members and Agency Personnel.

II. Donna Balaski, of DSS, began the presentation on Non-Emergency Medical Transportation (NEMT) (See Attachment). She began with a brief overview of what the NEMT program is and the topics that would be covered throughout the presentation. DSS has been looking at other NEMT models and talking to CMS about what is allowable. Donna and her team are finishing recommendations that will be submitted to the Commissioner. She continued going through the PowerPoint, featuring the reorganization of administrative aspects of the NEMT Program and its outcomes.
https://www.cga.ct.gov/med/council/2015/0918/20150918ATTACH_NEMT%20Presentation%209-18-2015%20.pdf

Sen. Gerratana thanked Donna for her presentation. She asked for clarification on why people might be denied and how gas is reimbursed.

Kristen Hatcher asked about the review process for denials and how the client is notified. She shared her concern about the issuance of denials once every 60 days. CMS requires a notification for each denial.

Sheila Amdur asked for clarification on what DSS is doing compared to Logisticare administratively. She shared her concerns with Logisitcare. Kate McEvoy explained the Departments role and the structure of NEMT service.

Ellen Andrews asked for clarification on the numbers on the slides. She asked if there were efforts to combine appointments. Sheila asked if there was a group of high utilizers and if data could be provided.

Rep. Johnson asked about the process for parents joining their children on rides and asked about transit in rural areas. Donna provided some additional information.

Mary Alice Lee stated that children under 21 may have a parent/ guardian accompany them for a NEMT ride.

Christine Bianchi asked about the issues in the contract and sanctions. Donna stated that she recently issued a sanction that was admissible in the contract. She added that it is difficult to give sanctions under the current contract.

Deb Polun asked if CT has looked at how other states provide NEMT. Donna discussed how different other states are, and the challenges with NEMT.

III. Marc Shok, of DSS, began the presentation on the Application Timeliness of the Husky Program (See Attachment). He began with an overview of the presentation which would include information on Application Timeliness, and overviews on the MAGI Medicaid Process, 2014 Open Enrollment, Tactical Approaches, Strategic Approaches and 2015 Open Enrollment.

https://www.cga.ct.gov/med/council/2015/0918/20150918ATTACH_DSS-%20Application%20Timeliness%20Update%209-18-2015%20.pdf

Deb Polun asked for clarification on whether persons are officially enrolled or not after going through Enrollment through Access Health CT. Discussion followed on Temporary ID's, and point of enrollment.

Christine asked of the 40,000 temporary ID's that were issued, how many claims came through. Kate McEvoy stated that DSS tracts that information and that the one instance she knew of was with Behavior Health claims and due to lack of knowledge with the process.
Christine asked how the process worked with Newborns. Marc Shok explained the process, but would need to follow up with RFP's for timeliness.

Kristen Hatcher asked how long it takes for the individual ID to be issued and how long the temporary ID lasts. Kate added a few comments distinguishing the difference of the ID's.

Marc continued the presentation, which he believed would help answer questions.

Cindi Delfavero asked if the timing of the Medicaid Savings Program was similar to Husky. Marc replied that the Husky C program included those applications. The MSP does not currently have auto-renewal.

Mary Alice Lee asked about the Enrollment in Husky of August which was down and how long it will take for DSS/Xerox to catch up on re-eligibility. Marc replied that the plan is to have everything caught up by November 1, the beginning of open enrollment and then enrollment numbers should begin to catch up.

Deb asked if the Dashboard could reflect the difference in time between an automatic renewal and someone going through enrollment.

III. Sen. Gerratana asked for an Overview on Medicaid Quality Improvement and Shared Savings Program. There will be an overview of MQISSP at the next meeting.

Kate went over a set of documents that were distributed and also online. She included an overview of the work of the Care Management Committee and Department including the timeframe of the project.

Kate went over the future meetings of the Care Management Committee and what they would focus on.

Sen. Gerratana thanked Kate and went over how she finds the new model which is driven on data very innovative and exciting.

Sheila commented that the Duals Demonstration on the infographic needs to be updated.

IV. Mary Alice Lee briefly went through the three reports, from CT Voices for Children, which were distributed at the meeting. She asked about the filing of taxes and 1095 forms and how they will work in Medicaid. DSS confirmed that they could go over that at the next meeting. Discussion followed on changes in coverage.

Kate went over the process diagram of the DSS process and benefit center which was distributed at the meeting (See Attachment). She added that the latest ConneCT Dashboard was updated on the Department's website.

https://www.cga.ct.gov/med/council/2015/0918/20150918ATTACH_DSS%20Benefit%20Center%20Process%20Flow%20Chart.pdf

Mary Alice asked for an update on the monthly enrollment of the Husky program for the October meeting.

With no other business, Sen. Gerratana thanked all the presenters and members.

The meeting was adjourned at 11:56 AM.

The next meeting will be held on **Friday, October 9, 2015 at 9:30 AM**

MEETING MINUTES

Friday, October 9, 2015

9:30 AM in Room 1E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:36 by the chair, Rep. Johnson.

Introductions were made by Council Members and Agency Personnel.

Rep. Johnson stated that Sen. Gerratana and Ellen Andrews were attending a conference on Medicaid ACO's and listed those who reported they could not make the meeting.

IIA. Kate McEvoy introduced Melissa Garvin of DSS, who would be giving the report on Eligibility Process Improvement. She began with the agenda of the presentation which would review the business process, ongoing efforts and the October Dashboard (See Attachment).

https://www.cga.ct.gov/med/council/2015/1009/20151009ATTACH_DSS%20-Eligibility%20Process%20Improvement%20Update;%20October%209,%202015.pdf

Rev. Bonita Grubbs asked if there was a list of areas where further improvement is needed. Melissa answered that nothing is off the table and everything is constantly re-evaluated. DSS is currently exploring having a client survey.

Sheldon Toubman asked if specific numbers could be included and if DSS could share an actual goal. Marva Perrin of DSS stated that the data is constantly reviewed and they are trying to figure what are acceptable goals based on trends.

Kathy Yacavone asked if during a call there is a notification of how much time is left to wait. Melissa explained that it is based on thresholds due to the variability in volume of calls. Kathy feels it would be best to give clients calling as close of a time frame as possible.

IIB. Kate McEvoy thanked her colleagues in Eligibility for their presentation. She shared the news on behalf of CHN that they received an Audit for their ASO services and received a 100 percent score. Sylvia Kelly shared CHN's pleasure with their score which is reflective of staff's hard work. Rep. Johnson added comments about CT's Medicaid services.

Sheila Amdur acknowledged Kate, who is one of six directors of state's Medicaid programs that were chosen to participate in leadership trainings CMS is undertaking. Kate briefly explained the opportunity she would now have. She intends to report to the Council over the next year and explained her focus. Rep. Johnson talked about legislation that was passed last session regarding PTSD for homeless children and thanked Kate for her work.

Kate invited Charles Lassiter of Mercer to join her for the presentation on the Medicaid Quality Improvement and Shared Savings Program (MQISSP). Mercer is contracted to advise DSS on the framing of Model Design for MQISSP. Kate thanked the chairs and members of the Care Management for the work they have done over the past few months. Kate began to go through the documents that were distributed (See Attachments). They are all located on MAPOC's website.

https://www.cga.ct.gov/med/council/2015/1009/20151009ATTACH_DSS%20-%20MQISSP%20Overview;%20October%209,%202015.pdf

https://www.cga.ct.gov/med/council/2015/1009/20151009ATTACH_MQISSP%20Key%20Model%20Design%20Documents%2010-5-15.pdf

Kate outlined her goals for the presentation which included an overview of MQISSP, providing a context setting, reviewing the model design process and key design features.

Sheila Amdur asked about who was being targeted under the initiative. Kate asked for everyone to review the elements document which lists the targeted population of MQISSP and walked through it.

Rep. Johnson asked a question about slide 36 with the reduction in ED usage and how observation status fits into that. Kate stated that they will have to examine that at respond more formally. Dr. Zavoski added that he did not know if those numbers were separated.

Matthew Barrett asked for clarification on the model and advanced care coordination payments. Kate stated that it was felt that the MQISSP model was the best balance for the Medicaid program.

Charles Lassiter began an overview of provider qualifications and shared savings specifications. Kate discussed the under-service monitoring strategies. Charles continued discussing some of the elements that provide risk for underservice and continued with reviewing shared savings. Kate provided the next steps of the model design process and welcomed all questions and comments from the Council.

Rep. Johnson thanked Kate and Charles for their presentation on MQISSP.

Rev. Grubbs offered that she is willing to participate in helping in any way she can.

Sheldon shared that those who are included and excluded in the program is not finalized, referencing a letter from NAMI submitted to DSS. He also stated that in order for an entity to participate in MQISSP they must already be participating in PCMH. Sheldon finds it concerning because at the SIM steering committee several people objected to that, feeling they wanted more people to participate and worrying about not knowing the outcomes. He expressed that one of the principles he wants to see is that if you don't meet the underservice measures you don't get an opportunity at any pool of funds. Charles stated that this was built into the model and would be reflected. Sheldon referenced Slide number 39 and the implication that the successful PCMH program is an example of switching to value based approach. He found this to be contrary to what Mark Schaefer had stated at a SIM meeting and asked for comment from DSS. Kate stated that it might be useful to distribute a chart done by Chartis for SIM. She explained the difference

between people viewing this as a continuum versus a reference and discussed MQISSP moving to an upside only model which she believed was different then what Dr. Schaefer was stating.

Dr. Zavoski added that at SIM's meeting the NCQA discussion is sometimes compromised by the division of providers. Rep. Johnson stated that she is happy to see the Department recognizing and moving forward with their initiatives. Dr. Zavoski thanked Sheldon and talked about how this was a development and new territory for Medicaid.

Mary Alice Lee referenced slide 30 and the quarterly cost per member trending downward and requested it be reported by beneficiary group. Sheila added that she finds such information would be very important and help in providing care coordination for certain populations. She stated that she hopes no one is counting on big savings from the program.

Kathy stated she was happy to see a lot of the work that was done in the SIM Equity and Access Council is being reflected in MQISSP and is glad that there is an extension in which we will now be able to spend more time developing.

III. Mary Alice Lee, began her presentation on the Husky Performance Monitoring done by CT Voices for Children (See Attachment).

http://cga.ct.gov/med/council/2015/1009/20151009ATTACH_CT%20Voices%20for%20Children%20-%20Impact%20of%20MCO%20to%20ASO%20transition%20(MAPOC%2010.9.2015).pdf

Rep. Johnson thanked Mary Alice for her insightful presentation.

Sylvia Kelly followed up by stating that no improvement was shown between 2012 and 2013 because Hospitals were not reporting V-codes. She went over another initiative regarding preventative care for children under 15 months old, where parents receive multiple phone calls to make sure they are going to a pediatrician. Sylvia discussed the data that is being provided in real time on ED's and the positive improvements that have and will be made with it. Dr. Zavoski provided context of what has happened moving to a fee-for-service model and the data that is being gathered.

Sheldon commented on the fight that went on for years to switch from managed care and discussed the improvements and results within the PCMH program. Mary Alice expressed the limitations on analysis based on the data they receive from DSS. She stated her intentions and that she finds the program changes are good and leading to improvements.

Deb Polun added comments about the growth in Health Centers with the Affordable Care Act and the data on ED visits that would greatly help. She discussed the possibility of partnerships reaching out to the parents of young children.

Renee Coleman-Mitchell discussed the Department of Public Health's work with DSS on ED visits and a specific focus on those related to Asthma. Rep. Johnson discussed legislation that looks at chronic conditions. Sylvia referenced the differences in populations and the work that will be done based on data. Dr. Zavoski added that Asthma is a big focus right now and applauded Mary Alice for her work.

Dennis Cleary asked about notifying people about alternatives to the ED. Sylvia explained a mailer that was sent out informing households of alternatives. Kate reiterated the work she will be doing through the NGA on high need, high cost utilizers and the need for a definition and clarification of Emergency/Urgent Care. She talked about expanding para-medicine and the recommendations that are being prepared by the Department.

IV. Rep. Johnson stated that the Complex Care Committee would be meeting on the 23rd and continuing its work on high cost, high need utilization.

V. Rep. Johnson announced the next meeting date for the full Council and listed what would be on the agenda for November.

With no other business, Rep. Johnson thanked all the members.

The meeting was adjourned at 11:56 AM.

The next meeting will be held on **Friday, November 13, 2015 at 9:30 AM**

MEETING MINUTES

Friday, November 13, 2015

9:30 AM in Room 1E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:39 by the chair, Rep. Abercrombie.

Introductions were made by Council Members and Agency Personnel.

Rep. Abercrombie listed those who reported they could not make the meeting.

IIA. Marc Shok began with an update on Husky enrollment over the past 12 months. (See Attachment)
https://www.cga.ct.gov/med/council/2015/1113/20151113ATTACH_HUSKY%20Enrollment%20Update;%20Novemer%2013,%202015.pdf

Marc first gave an overview of the new application and MAGI-Based Renewals process. He then provided explanation for the fluctuations in enrollment.

Steve Frayne asked if there was a reason why there is still not electronic communication between the systems. Marc explained the work on Impact which will replace the current EMS system. It is scheduled to begin in March of 2016.

Dennis Cleary asked for clarification on presumptive eligibility and auto-renewal. During the 90 day verification period members retain coverage.

Mary Alice Lee asked Marc to walk through the timeline of when an application is submitted and when the 90 day process starts. Marc explained that eligibility is determined in real time and a notification for verification is sent out immediately. Mary Alice discussed the enrollment numbers and voiced her concerns of a decline in enrollment of Children.

Deb Poerio asked what the process was for notifying parents that more information is still required. Reminder letters are sent out at 30 days, 60 days and 75 days with a disenrollment letter sent out on day 90 if verification documents are outstanding. Sheldon Toubman asked if there was a 10 day notice of termination sent out.

Sheldon asked if Xerox is current with there .pdf processing. Marc responded that they are. Sheldon asked Access Health about complaints he had heard about wait times of their Maximus system, and length of time on the phone. James Michel stated that they are aware of some issues that they are working on. A system change that allowed multiple applications now refers someone online to contact a call center. Access Health representatives must now remove the additional application which can use up time on the phone.

Ellen Andrews explained circumstances where a consumer might have created more than one application. Rep. Abercrombie asked for clarification on creating or updating an application.

James Michel explained the process and examples of why there might be different applications. The system now allows only one active application. Rep. Abercrombie asked about the wait time on the phone. The archiving of the applications takes additional time. Robert Blundo, of Access Health CT, discussed the issues in password resets and being directed to the call center.

Mory Hernandez asked about multiple ID numbers and issues consumers have. Robert distinguished between transactional IDs and application IDs. He discussed the issues and how things will change going forward.

Suzanne Lagarde suggested letting the call center reset passwords while counselors process applications. James Michel explained how the call center works and what may cause more than average wait times. Rep. Abercrombie asked how many pages the application is. James explained the different applications and stated the full paper version is 23 pages. Rev. Bonita Grubbs expressed her opinion on the length of the application and asked if examples of the notifications and letters could be shared.

Katherine Yacavone asked if the number of call center operators has been increased. James Michel stated that about 400 call center representatives have been added for open enrollment and that they are new. DSS and Access Health are looking at the amount and content of notifications being sent out. Deb Poerio discussed the Consumer Access subcommittee looking into some of the issues discussed.

III. Rep. Abercrombie went to item number three of the agenda due to its relevance of conversation.

Marc Shok began with an overview of the requirements under Public Act No. 15-5 (See Attachment).
https://www.cga.ct.gov/med/council/2015/1113/20151113ATTACH_HUSKY%20A%20Transitions;%20Novemeber%2013,%202015.pdf

Marc discussed the outreach and review that was done by the Department of Social Services based on the reduction in income limit. James Michel went through the review and outreach on behalf of Access Health CT. Marc and Robert went through the reporting requirements of Public Act No. 15-5 and shared the relevant data.

Ellen Andrews asked about the reported number on slide 12. Robert and Marc reviewed the details of the numbers provided.

Kathy Yacavone asked what happens to those people who lose eligibility next year. Marc explained transitional coverage and the larger scale that will take place next year.

Mary Alice shared that her and other community partners could help in the transition and tracking of people who lose coverage.

Rep. Abercrombie asked if the transitional coverage was the same as enrollment coverage and expressed that people need to be informed about their coverage loss and other options far in advance.

Sheldon Toubman asked about individuals and 3 persons whom are now eligible for HUSKY D. He also questioned if people who are pending a hearing are counted in the 532. Marc replied that individuals separated from their families and then qualified for Husky D. Marc did not have the data on those pending a hearing. Sheldon shared his concern that if those pending a hearing are included in the 532, they may lose coverage following the hearing.

Mary Alice shared her interest in the children who could be at risk by their parents losing coverage. She expressed her concern with how the income level limit has changed four times in the last 10 years and the negative impact this can have.

Anthony DiLauro asked for clarification on the numbers and who is losing coverage. Marc explained the eligibility rules and process of going through the Access Health system to find who would be affected.

Rev. Bonita Grubbs expressed the need to look at the impact the transition will have on the parents and their children.

Dennis Cleary asked about the budget numbers and what the anticipated savings are. Marc would follow up with numbers at a future meeting. Rep. Abercrombie expressed the complication with anticipating savings for the budget.

Ellen asked for clarification on those who were able to move to Husky D. Alex Geertsma expressed his concern about the effect losing coverage could have on this vulnerable population.

Steve Frayne asked for additional information on what happens when the transitional coverage is up. Marc talked about the process of reviewing what people would be eligible for when their transitional insurance is done on July 31, 2016. Mary Alice Lee asked for clarification on the CDC early detection program.

IIB. Kristen Dowty provided an overview of the new 1095 Tax Form required under the Affordable Care Act (See Attachment).
https://www.cga.ct.gov/med/council/2015/1113/20151113ATTACH_1095B%20Tax%20Form%20Information;%20Novemeber%2013,%202015.pdf

Cheryl Wamuo asked what happens if the form goes to the wrong address. Kristin explained that a separate notice that is going out early should help mitigate some of the issues with address changes and that a person would be able to call a call center and request another form to be sent out.

Ellen asked if the form need to be submitted. Kristen explained that they are required to send the form so consumers can accurately report during their tax filing but it does not need to be sent in to the IRS at that time.

IV. Alex Geertsma requested a review of the mandates and purposes of the subcommittees which he believes do not give many reports. Rep. Abercrombie suggested that the subcommittees put together some information and believes it is time to look at their roles and the work they are doing. She shared information on the upcoming Care Management Meeting.

V. Anne Foley provided Rep. Abercrombie with some numbers on the anticipated savings from the reduction in income eligibility.

Rep. Abercrombie referenced the document: A Brief Overview of Connecticut's Participation in the National Governor's Association High Need, High Cost Policy Academy (See Attachment). https://www.cga.ct.gov/med/council/2015/1113/20151113ATTACH_A%20Brief%20Overview%20of%20Connecticut's%20Participation%20in%20the%20National%20Governor's%20Association%20High%20Need,%20High%20Cost%20Policy%20Academy.pdf

Rep. Abercrombie announced the next meeting date for the full Council and what was anticipated to be on the agenda.

With no other business, Rep. Abercrombie thanked all the members.

The meeting was adjourned at 11:32 AM.

The next meeting will be held on **Friday, December 11, 2015 at 9:30 AM**

MEETING MINUTES

Friday, December 11, 2015

9:30 AM in Room 2E of the LOB

Attendance is on Record with the Council.

I. The meeting was called to order at 9:39 by the chair, Rep. Johnson.

Introductions were made by Council Members and Agency Personnel.

Rep. Johnson reported that Rep. Abercrombie would not be able to make the meeting.

II. Kate McEvoy of DSS began the overview of Connecticut's Participation in the NGA High Need, High Cost Policy Academy (See Attachment).
https://www.cga.ct.gov/med/council/2015/1211/20151211ATTACH_NGA%20high%20cost%20high%20need%20-%20FINAL.pdf

Kate provided the committee with contextual background for the presentation. She went over the agenda which would feature an overview of the NGA policy academy and Connecticut application, historical context, current Connecticut Medicaid strategies, and an initial profile of high need, high cost Medicaid members.

Rep. Johnson asked if the collection of data was a focus of the academy. Dr. Zavoski discussed a meeting that took place in July and the way CT collects data compared to other states.

Rep. Johnson asked what the process would be to share some of the information Kate was providing to the Legislature.

Sheila Amdur shared her concerns of high need high cost individuals and disproportionate representation.

Mark Keenan believed DPH could be more involved in the academy and offered Kate information he could share.

Dr. Zavoski gave his opinion on Emergency Department Utilization. Dr. Geertsma discussed evidence based advice giving. Kate discussed a medical intervention in Utah called "safe to wait."

Mary Alice Lee asked for information on the amount of people in the ICM program. Discussion was had on ED utilization and whether it is "high." Dr. Zavoski believes that the approach under the current model of care shows drops in ED visits. Silvia Kelley discussed the effort to get Husky D members connected to a PCP. Beth Cheney gave her point of view on ICM as a PCP. Kate discussed getting data through the federally funded TEFT grant.

Rep. Johnson discussed the issues with observation status. Stephen Frayne added that Hospitals are in favor of trying to solve some of the problems of observation status. Rep. Johnson shared

some of the difficulties with making changes to observation status at the federal level. Kathy Yacavone discussed the continuing need to educate patients and offer expanded hours of service for other options instead of the ED.

Rep. Johnson discussed the applied income situation of beneficiaries who are in nursing home facilities. Kate discussed the problems with Federal law and the possibility of having a discussion with Marc Shok who is the director of eligibility at DSS.

Bill Halsey went over the initial review of data.

Cynthia DelFavero asked about the statistics on demographics and if there were health disparities present. Bill Halsey said that this would be monitored throughout the program and Kate discussed some of what SIM has been doing on health equity. Cynthia asked for a breakdown of Medicaid beneficiaries by County. Mary Alice asked that one-time events like pregnancy be separated in the data. Christine Bianchi asked if the total percentage for the state based on demographics could be included in future presentations.

Deb Polun shared some of the preliminary findings of CHCACT on their high cost, high utilizers. Kathy Yacavone added comments on the benefit of looking at ED diagnosis.

Stephen Frayne asked about the children in Husky D. DSS includes up to age 21 as children while persons over 18 can be in Husky D.

Ellen Andrews stated she was happy with current numbers in health equity which she anticipated to be worse. She asked why about twice as many adults were being admitted to the hospital in comparison to children. Dr. Zavoski explained the relative numbers and challenges with costs with certain illnesses.

Discussion was had on Dental Health care. Rep. Johnson thanked DSS for their presentation and ongoing work.

III. Rep. Johnson gave a review of the draft 2015 MAPOC Report to Legislature (See Attachment).
https://www.cga.ct.gov/med/council/2015/1211/20151211ATTACH_Draft%20-%202015%20Council%20Biannual%20Report%20-%20Full.pdf

Sen. Gerratana added comments on the Report and suggested members provide feedback. Deb Polun and Mary Alice suggested that a list of membership be included in the report.

IV. Subcommittee Report (See Attachment)
https://www.cga.ct.gov/med/council/2015/1211/20151211ATTACH_November%20-%20December%20Subcommittee%20Repot.pdf

Alex Geertsma reiterated his request given at the last meeting of a defined structure of the subcommittees. He shared his disappointment in the Quality Improvement Committee no longer meeting and his belief that now was the time for it to begin meeting again. Dr. Zavoski provided background information on CT CHIP that was started but did not continue due to a lack of resources. He agreed that Quality Improvement should be restarted.

Sheila Amdur reviewed what the Complex Care Committee would be doing in January.

Rep. Johnson talked about what took place at the previous Women's Health Committee meeting.

V. Kate McEvoy provided a brief overview of what DSS intends to present to the Council in January.

Dr. Geertsma talked about how there is a need to publicize the reform that has happened in this state, which is contrary to what is happening in much of the rest of the U.S. Sen. Gerratana talked about a conference in New Jersey she attended and the positive response she got from attendees.

Kate McEvoy announced that an updated ConneCT dashboard was online.

Rep. Johnson announced the next meeting date.

With no other business, Rep. Johnson thanked all the members.

The meeting was adjourned at 11:32 AM.

The next meeting will be held on **Friday, January 8, 2016 at 9:30 AM in Room 1E**

Richard Eighme
Council Clerk